CHAPTER TWENTY FIVE

The General Medical Council's New Fitness to Practise Procedures

Introduction

25.1 In the preceding Chapters, I have described in some detail the General Medical Council's (GMC's) fitness to practise (FTP) procedures as they have operated over the years since Shipman's case was considered by the GMC in 1976. It will be apparent that there have been many changes during that time, not least the introduction of the health and performance procedures. The conduct procedures, including the GMC's way of dealing with doctors convicted of criminal offences, have undergone evolutionary, but not radical, change. For some years, beginning in the late 1990s, the GMC has been aware that its procedures were not satisfactory, and were in need of fundamental change. By November 2003, when the focus of the Inquiry hearings was on the GMC, the process of change was well underway and it was expected that the 'new' procedures would be brought into effect by the spring of 2004. In the event, there was some delay and the relevant Rules came into effect only recently, on 1st November 2004.

25.2 In this Chapter, I propose to examine the way in which the new procedures are expected to operate. As will be apparent from this Chapter, the proposals have changed considerably even during the period in which the Inquiry has been focussing its attention upon them. However, at a Council meeting on 15th September 2004, the GMC approved the draft Rules which were to form the basis of the new procedures. With the exception of a few minor changes, those draft Rules were identical to the Rules which came into force in November. It is by reference to the November 2004 Rules that I shall discuss the operation of the new procedures. However, to some extent, my work is likely to become out of date even as I write, because it is almost inevitable that some changes will be made to the new procedures as the result of early experience.

25.3 It is, in my view, important that the Inquiry considers the new procedures in detail. The Inquiry has identified various shortcomings in the way in which the old procedures operated. In some respects, they did not provide adequate protection for patients. Some cases that should have entered the procedures were closed by the administrative staff at the initial stage. In general, there was no investigation in the early stages, so that the potential seriousness of some allegations was not fully appreciated and others, although obviously serious, foundered. Some cases were closed at the screening stage or by the Preliminary Proceedings Committee (PPC) as a result of the wrong application of the appropriate tests or the application of the wrong tests. Lack of standards, criteria and thresholds for decision-making produced inconsistent outcomes. Any of these shortcomings can give rise to a danger that a doctor who presents a risk to patients is not detected and dealt with. Another problem with the old procedures was that they lacked transparency. In the modern world, the public expects and is entitled to see what is being done by a regulatory body and to understand why. For those reasons, it is important that the Inquiry examines the extent to which the new procedures will correct the shortcomings of the old.

25.4 I also regard it as important to see how the proposals for the new procedures have developed over the last three years. As will become apparent, there have been many changes of direction: some quite minor, some major. In the context of the development of new procedures, some changes are inevitable. Some have led to improved proposals that will result in greater consistency and openness, and will provide improved patient protection. Those changes have been made in part as the result of consultation and in part as the result of the GMC's awareness of the evidence given to this Inquiry. Other changes appear to me to have been retrograde. It is important, in my view, to examine those changes and to try to understand why the GMC has made them. If the GMC has made a change that results in reduced patient protection or reduced transparency, that is a cause for concern, as it might suggest that the GMC has not fully accepted the need to improve patient protection and transparency. It raises the risk that further such change might occur in the future.

25.5 At times in this Chapter, I suggest that the GMC should consider doing things in a different way. It may be said that it is not part of my remit to make detailed recommendations about internal matters. In my view, it is within my remit. If I had come to the conclusion that I should recommend that the GMC should lose its FTP function altogether, there would be no point in making detailed suggestions for change. However, as I have not, I think it is necessary to descend into the particulars of those aspects of the new procedures that I consider do not provide adequate protection for patients. I make these suggestions in a constructive spirit in the hope that they will be given serious consideration by the GMC and also because they might be useful to the Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare Regulatory Excellence (CRHP/CHRE)), in seeking to promote patient protection and transparency across all the healthcare regulatory systems.

25.6 As before, all references to the old procedures are made in the past tense and I shall speak of the new procedures as if they will come into force in the future.

Preparations for Change

25.7 In 1997, the Fitness to Practise Policy Committee (FPPC) of the GMC was established. It was chaired by the then President, Sir Donald Irvine. The functions of the FPPC included responsibility for reviewing the statutory framework governing the FTP procedures and for making proposals for amendment where appropriate.

25.8 The FPPC set up several working groups, including the Professional Conduct Committee (PCC) Working Group, to which I referred in Chapter 21, and the Screening and PPC Working Group. The reports of both Working Groups became available in 1999. Following the publication of those reports, and the debate which they provoked, the FPPC produced a discussion document, seeking ideas for changes to the FTP procedures. The discussion document sought views from members of the GMC on a wide range of issues, including the purpose of the GMC's FTP procedures, appropriate sanctions, interim orders, restoration to the register, the possible integration of the conduct, health and performance procedures and the operation of the FTP procedures generally.

25.9 In March 2001, the GMC issued a Consultation Paper, 'Acting fairly to protect patients: reform of the GMC's fitness to practise procedures' (the 2001 Consultation Paper), which set out a number of options for reform of the FTP procedures and sought views on them. It also set out some principles that it was considered should underlie the development of the new procedures, together with criteria by which they were to be judged. The criteria required that the procedures must be, *inter alia*, fair, objective, transparent, free from discrimination, effective, prompt, proportionate, understandable, compatible with the Human Rights Act 1998 and regarded with confidence by the public and the profession.

25.10 The 2001 Consultation Paper identified those features which the GMC perceived as the strengths of the old FTP procedures. The first of these was that enquiries which were **'obviously trivial or incoherent'** or **'not relevant to the role of the GMC'** could be dealt with quickly within the GMC office. Second, it was said that the recently acquired (in 2000) powers to impose interim suspension or conditions on registration pending investigation and determination of a complaint against a doctor meant that the GMC could act quickly when it appeared that a doctor was a danger to the public or to him/herself. Third, the 2001 Consultation Paper pointed out that the new performance procedures permitted investigations to proceed along a formal, but voluntary, route, with the co-operation of the doctor, so that the doctor's problems could be investigated and, if possible, put right **'without the delay and expense of the doctor having to appear before a committee simply to agree points which have already been conceded'**.

25.11 The 2001 Consultation Paper also identified certain disadvantages of the old conduct and performance procedures. First, there was limited investigation before a decision was made on what to do with a case. Second, it was said that the tests applied when determining whether a case should proceed had very low thresholds. It was suggested that this might result in **'groundless cases'** being referred to the PCC. As well as the thresholds being very low, it was suggested that the tests applied to conduct cases at each of the various filtering stages (by the office staff, the screener and the PPC) were very similar, which raised the question of whether all three stages were needed. Fourth, it was said that the decision on how to take a case forward (especially the choice between the conduct and performance routes) was taken at a very early stage and could not later be reversed, even when further evidence would have made that desirable. Finally, the 2001 Consultation Paper observed that the arrangements for issuing letters of advice to doctors lacked transparency and were not regarded as fair or effective by complainants or doctors.

25.12 The 2001 Consultation Paper also acknowledged that the old procedures did not satisfy most of the criteria by which it had suggested that the new procedures should be judged. It observed that the processes involved in the existing FTP procedures could be slow and cumbersome and involved considerable duplication of effort by GMC members and office staff. They also lacked transparency. It referred to successive judicial reviews of conduct cases in which, it was said, the tests to be applied in the early stages had been interpreted as allowing very little discrimination to decision-makers, with the result that those stages were not effectively sifting out the cases which should not be considered fully by the PCC. The FTP procedures did not, the 2001 Consultation Paper suggested, command the confidence of the public or of doctors. A new approach was required **'which builds on**

the strengths of the existing system but which addresses its structural weaknesses'. I am not sure that the weaknesses identified were exclusively structural. However, it is clear that the GMC was contemplating radical change.

25.13 In May 2001, the Fitness to Practise Review Group (the FTP Review Group) reported the results of the consultation process to the full Council. Detailed proposals were then developed and a paper (which appears to have been produced by the FTP Review Group) was considered by the Council at its meeting in November 2001. At that meeting, a number of important decisions of principle were taken relating to the new procedures; I shall refer to some of these in due course. During 2002, there were further discussions within the GMC about the detail of the proposals for reform. Those discussions resulted in the production of an internal discussion paper, 'Review of Fitness to Practise: The New Model', in October 2002. That paper subsequently underwent amendment; the version in the Inquiry's possession is dated 22nd November 2002. A further paper produced by the FPPC was discussed by the Council at its meeting in November 2002. Some amendments were made to the proposals at that stage.

25.14 Before the new procedures could be adopted, changes to the legislation were required. Accordingly, in December 2002, the GMC obtained certain amendments to the Medical Act 1983 (the 1983 Act). These were effected by the Medical Act 1983 (Amendment) Order 2002. New Rules were also needed. Accordingly, in July 2003, the GMC published the draft General Medical Council (Fitness to Practise) Rules 2003 (the 2003 draft Rules), with accompanying Guidance. A period of consultation on the 2003 draft Rules followed. That period of consultation finished at the end of October 2003.

25.15 In November and December 2003, witnesses from the GMC gave oral evidence to the Inquiry. Some of them – in particular Mr Finlay Scott, Chief Executive, and Professor Sir Graeme Catto, President – gave evidence about the new procedures. As I have said, it had been intended that the new procedures would be in place by the spring of 2004. By the time of the Inquiry hearings, however, it was clear that their introduction was going to be delayed. In the early part of 2004, the GMC reviewed its proposals for the new procedures. This review was carried out partly in response to concerns about the original proposals that had been raised at the Inquiry and partly as a result of issues that had emerged from the consultation process. The review resulted in important changes to the new procedures which, in turn, necessitated substantial changes to the 2003 draft Rules. In May 2004, the GMC published a revised version of the draft Rules (the May 2004 draft Rules), together with further Guidance. A short period of consultation on the May 2004 draft Rules followed.

25.16 In July 2004, the GMC published a third version of the draft Rules (the July 2004 draft Rules). They were accompanied by further Guidance. The July 2004 draft Rules contained further significant changes to the proposed new procedures. A fourth version of the draft Rules followed in September 2004. These contained only minor changes to the July 2004 draft Rules. They were accompanied by yet further Guidance. The September 2004 draft Rules (with a few further minor changes) were adopted by the GMC at its Council meeting on 15th September 2004 and came into effect, as I have said, on 1st November 2004. I shall refer to this fourth version as the November 2004 Rules.

25.17 During the five years for which the new procedures have been under discussion, there have been a number of fundamental changes to the arrangements proposed. I do not intend to trace all those changes in detail. Instead, I shall discuss the new procedures as they were proposed in 2003, when the first set of draft Rules was produced. I shall then examine the very different procedures now proposed. Before doing so, I shall summarise briefly the way in which the new procedures are intended to operate.

The Operation of the New Procedures: a Summary

25.18 Under the new procedures, cases will be dealt with in two stages: the investigation stage and the adjudication stage. The new section 35C(4) of the 1983 Act, as amended, provides that, when an allegation is received by the GMC that the fitness to practise of a doctor is impaired, the GMC's Investigation Committee (IC) shall investigate the allegation and decide whether it should be considered by a FTP panel. Under section 35C(2), a doctor's fitness to practise shall be regarded as impaired by reason only of misconduct, deficient professional performance, conviction or caution, adverse physical or mental health or by reason of a determination of another relevant professional regulatory body to the effect that his/her fitness to practise is impaired. For brevity, I shall refer to this last ground as 'a determination'.

25.19 As I have said, the purpose of the investigation stage is to decide whether an allegation should be considered by a FTP panel. The 1983 Act does not lay down a test to be applied when making this decision. Nor do the Rules. However, the GMC has decided that this test (the investigation stage test) should be whether there is a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration. Only cases which satisfy the investigation stage test will progress to the adjudication stage.

25.20 Decisions at various points during the investigation stage will be made (depending upon the circumstances of the case) by members of the GMC staff (who will, as under the old procedures, carry out a preliminary 'sift' of cases), by medical and lay persons contracted to work for the GMC (to be known as case examiners), and by panels of the IC. It is likely that the vast majority of cases reported to the GMC will not progress beyond the investigation stage.

25.21 If, at the investigation stage, it is decided that the case should not be considered by a FTP panel, a decision may be made either to warn the doctor about his/her future conduct or performance or to close the case. There will also be cases involving a health or performance element where the investigation stage test is satisfied, but where the case will nevertheless not proceed to the adjudication stage. Such cases will be dealt with by the doctor giving voluntary undertakings in the same way as was previously possible under the voluntary health and performance procedures. The GMC is considering the possibility of extending the availability of voluntary undertakings to all categories of case; I shall discuss this proposal later in this Chapter. Cases dealt with by way of voluntary undertakings will remain in the investigation stage, with the possibility of being referred to the adjudication stage if, at any point, the doctor concerned fails to accept or co-operate with the voluntary arrangements or if his/her health or performance deteriorates or

otherwise gives rise to further concern about his/her fitness to practise. It should be noted that all this is subject to the qualification that there may be changes to the future arrangements for cases involving issues of health or performance as a result of the recent report of the Performance Procedures Review Group (to which I referred in Chapter 24) and of any recommendations which may be made by the Working Group currently undertaking a review of the old health procedures.

25.22 Cases referred to the adjudication stage will be heard by a FTP panel. The new section 35D of the 1983 Act provides the powers for a FTP panel to restrict or remove a doctor's registration if it finds that his/her fitness to practise is impaired. FTP panels are to replace the committee panels which previously dealt with issues of fitness to practise, namely panels of the PCC, the Health Committee (HC) and the Committee on Professional Performance (CPP). FTP panels will be composed of persons who are not members of the GMC but who have been appointed, selected and trained by the GMC for their role as panellists. Many of the associates who have, since 2000, been appointed by the GMC to sit on panels of its FTP committees will in the future sit on FTP panels. A FTP panel's task will be to decide whether the doctor's fitness to practise is impaired. If a FTP panel finds that a doctor's fitness to practise is impaired, it will then have to decide on the appropriate sanction to be imposed or on any other action to be taken.

25.23 There will be a separate Interim Orders Panel (IOP) for considering cases where it may be appropriate to impose an interim order restricting or suspending a doctor's right to practise pending investigation and determination of his/her case. This will replace the Interim Orders Committee (IOC) which, since its inception in 2000, has dealt with such cases.

The Separation of Functions within the Fitness to Practise Procedures

25.24 I shall now consider one of the principles which, according to the GMC, has underlain the development of its new FTP procedures, namely the separation of functions within those procedures.

25.25 In the past, the GMC's FTP procedures comprised two distinct functions. The first was (broadly speaking) to decide whether there was evidence that raised a question about a doctor's conduct, performance or health, which should be referred to a FTP committee or into the voluntary health or performance procedures, and to make any appropriate referral. This first function was comparable to the role of a prosecution service. The second function consisted of the hearing and determination of cases by a FTP committee. This function was comparable to the role of a court or tribunal and required administrative and other support. Initially, in its proposals for change, the GMC called the two functions the **'prosecution'** and the **'determination'** functions. Later, it adopted the terms **'investigation'** and **'adjudication'** functions. It should be noted that, in this context, the term **'investigation'** refers to an investigation as to whether a case should be referred to a FTP panel, and not to **'investigation'** in the sense of evidence gathering. In other words, it does not denote **'investigation'** in the sense that most people would understand the term. The term **'investigation'** is also something of a misnomer because the investigation

stage of the new GMC procedures includes a decision (or adjudication) as to whether the case is sufficiently serious to be referred to a FTP panel.

25.26 Historically, the same GMC members could be involved in both functions; sometimes, they could even be involved in both functions relating to the same case. Until the early 1970s, for example, the President acted as medical screener and chaired the Penal Cases Committee (the predecessor of the PPC); those roles were both part of the first **'prosecution'** or **'investigation'** function. The President could also chair the Disciplinary Committee (the predecessor of the PCC) which carried out the second **'determination'** or **'adjudication'** function. In practice, this ceased to happen in 1973, although it was permitted by the Rules until 1980, when the Rules were changed to restrict the President's decision-making role to either screening and Chairmanship of the PPC or Chairmanship of the PCC and/or the HC. The Rules were also amended to provide that no member of the GMC should sit on a case at the PCC, the HC or the CPP if s/he had previously been involved in making a decision in the case at an earlier stage, for example by screening the case or being a member of the PPC which had considered the case.

25.27 By 2000, the GMC had decided that the time had come to separate the two functions more clearly. This decision was, in part, prompted by the coming into force, in October 2000, of the Human Rights Act 1998, which incorporated into UK law the entitlement of a person to **'a fair and public hearing ... by an independent and impartial tribunal'** in the determination of his/her civil rights and obligations. However, the GMC had also become convinced that the existing arrangements gave rise to an appearance of unfairness. Doctors, it was said, perceived that the same organisation was both prosecuting them and sitting in judgement on them, and they considered that to be unfair. The GMC decided, therefore, that there was a need for the functions to be separated, so that everyone involved in complaints about doctors would be able to see that the organisation and the people making the final decision on a case were different from those who had taken the decision that it should be heard and from those representing any of the interested parties.

25.28 The GMC raised its proposal to separate the two functions in a Consultation Document, 'The Structure, Constitution and Governance of the GMC', published in October 2000. The proposal received general support.

25.29 In its 2001 Consultation Paper, the GMC put forward four possible models by which separation of the two functions might be achieved. The first model involved the retention by the GMC of both functions, although those functions would be carried out quite separately by different groups of personnel within the GMC. The intention was that the staff, management, legal support and records of the two groups would be located in two **'distinct organisational structures'** with separate arrangements for **'reporting and accountability'**. The 2001 Consultation Paper referred to the view of the supporters of this model that both investigation and adjudication functions were crucial to a regulatory body and that **'to hive off one or both of them would weaken professionally-led regulation by severing the feedback loops between fitness to practise and standards and education'**. The advantage of this model was said to be that:

> **'Professional ownership of the decision-making process is retained at all stages, and for some supporters of this model, it is the retention of ownership that defines professionally-led regulation.'**

25.30 The weakness of the model was said (in the 2001 Consultation Paper) to be the fact that decisions taken in both the investigation and adjudication stages would continue to be identified with the GMC. In addition, the arrangement might not have the appearance of fairness. The 2001 Consultation Paper acknowledged that there was a **'risk'** that the model would not **'go far enough'** to reassure the GMC's critics. However, the 2001 Consultation Paper also made clear that this model was the one preferred by the GMC.

25.31 The second model – and the GMC's second preference – was an arrangement whereby the GMC would retain the investigation function, with the adjudication function being **'contracted by the GMC to a completely independent, outside organisation'**. It was suggested that, in this model, it was **'the GMC, as guardian of standards and guarantor of the public interest, which should identify cases potentially raising questions about doctors' fitness to practise but that the decisions on those cases should be made by another organisation'**. The strength of this model was said to be the absolute separation that it created between the investigation and adjudication functions. It was suggested that the adoption of this model would absolve the GMC from blame when controversial decisions were made and might insulate the GMC from the disproportionate damage to confidence in the organisation and in **'professionally-led regulation'** caused by occasional controversial outcomes in FTP cases. It was suggested also that, with this model, the public might have greater confidence that decisions were being made purely on the merits of a case. The most obvious weakness of the model was said to be that the GMC would lose control over decisions concerning individual doctors and might still be perceived as responsible for the outcome. Furthermore, the fact that another organisation was ultimately responsible for the outcome of FTP cases might, it was suggested, undermine confidence in the GMC. Other disadvantages of the model were said to be the considerable resource implications involved and the fact that accountability might be weakened. I interpose at this stage to say that, in my view, the GMC was right to recognise the advantages of this model, although it also noted some drawbacks. In Chapter 27, I recommend that the GMC adopts this model, in order to achieve the separation of function which is, in effect, required by the Human Rights Act 1998.

25.32 The third model (described in the 2001 Consultation Paper as the **'mirror image'** of the second model) was an arrangement whereby the GMC would retain the adjudication function, but not the investigation function. GMC members and others appointed by the GMC would sit on FTP committees and GMC staff would be responsible for organising and servicing those committees. An outside organisation would be responsible for the initial stage of sifting complaints and referrals and deciding which cases raised questions about doctors' fitness to practise and should proceed. The 2001 Consultation Paper expressed the view that, by adopting this model, the GMC **'would be taking the view that its core business concerned only the final determination of the small proportion of cases which reached the stage of a committee hearing'**. It identified a risk that **'the links between fitness to practise and other core GMC functions would be weakened'**. I interpose to say that the 2001 Consultation Paper did not explain how those links operate and how the risk of weakening would arise. This is not clear – to me at least. The 2001 Consultation Paper declared that the process of investigation, in particular decisions about which cases to investigate, must be **'rooted in the GMC's own values'**. The

possibility that accountability would be weakened by the involvement of two organisations in the FTP procedures was also mentioned. In the 2001 Consultation Paper, the GMC expressed the view that **'hiving off the investigation function'** would **'seriously weaken public confidence in the organisation as protector of the public interest'**. It was said to be **'essential to confidence in professionally-led regulation'** that the GMC should be seen to **'act vigorously on questions about doctors' fitness to practise'**. However much another organisation tried to base its approach on the profession's values and ethical standards as embodied in the GMC, it was said, it would always be **'at one remove'**.

25.33 The fourth model would have delegated both the investigation and adjudication functions to separate outside organisations. A complaint would be investigated by one body and brought before another for adjudication. The GMC would have no involvement in either stage beyond, possibly, acting as the recipient for complaints before handing them on to the outside body for investigation. The 2001 Consultation Paper pointed out that this model would effectively end the GMC's involvement in fitness to practise. It suggested that it **'would be a clear statement that it** (*i.e. the GMC*) **no longer had a role in policing unfit doctors'**. The 2001 Consultation Paper suggested that the model would **'lack coherence and credibility and would not meet the expectations of either the public or the profession regarding what was expected of a professional regulatory body concerned with medicine'**.

25.34 The vast majority of medical organisations and individuals who responded to the 2001 Consultation Paper favoured the first model, i.e. the retention by the GMC of both the investigative and the adjudication functions. Patients' representatives were marginally in favour of the first model, with several preferring the second model.

25.35 In the event, the new FTP procedures appear to be based largely on the first model described. The GMC will retain responsibility for the investigation function. It will carry out the preliminary sifting of cases and will be responsible for the decision whether or not a case should go forward for a full hearing. The preliminary sift will be carried out by the GMC staff and the decisions as to whether or not those cases which survive the sift go forward to a full hearing will be taken by case examiners, who will be medical and lay people, contracted to work for the GMC on a part-time basis. Some such decisions will be taken by the IC.

25.36 The decision-making at FTP panel hearings will be undertaken by associates, both medically qualified and lay, who will not be members of the GMC but who will have been selected and appointed by the GMC to sit on those panels. Members of the GMC will not sit on FTP panels, although some of the panellists will be former members. Over 200 associates have already been appointed to sit on panels and, since 2000, they have sat on panels of the old FTP committees. Further panellists will be appointed as and when necessary. Panellists are expected to commit at least 20 days a year to their work for the GMC. They are selected for appointment against specific criteria and after an open competition. Appointment is subject to a two-day training programme. The training and evaluation of panellists is undertaken by the GMC. The GMC provides guidance for panellists on the approach to sanctions and other matters and will continue to do so. It is

intended that panellists, once appointed, will undergo regular appraisal and performance management, to be undertaken by the GMC. In the event that concerns arise about a panellist's suitability to continue to sit on a panel, a sub-group of the Fitness to Practise Committee will consider those concerns and may, if it thinks fit, terminate a panellist's appointment. If the GMC considers that a FTP panel has reached an inappropriate decision, the chairman of the panel may be given advice, presumably about where s/he and his/her panel have gone wrong. Members of the GMC staff will retain responsibility for organising and administering adjudication hearings and for choosing panel members to sit in individual cases.

Comment

25.37 The GMC started from the premise that it would be right to separate the investigation and adjudication functions. There were good, sound reasons for wishing to achieve that end. Yet this has not happened. The GMC has kept complete control over the investigative function which it has extended so that it encompasses some decisions on final disposal other than closure (the giving of warnings and the acceptance of voluntary undertakings) but it has not relinquished control of adjudication. Under the new procedures, it will have almost exactly the same degree of control over adjudication as under the old. For many years, PCC panels comprised GMC members only. However, by 2000, the pressure of work on the GMC was such that it was obliged to recruit extra people to serve as panellists alongside GMC members. As I have explained, from 2003, when the number of GMC members was reduced to 35, FTP committee panels were, in the main, composed entirely of associates. This situation is to be carried through into the new procedures. So, despite the GMC's recognition of the need for some separation of functions and some independence at the adjudication stage, nothing is going to change.

25.38 The GMC has retained very close control over the adjudication process. It has the power to select and appoint FTP panellists. It will train them, appraise them and provide them with guidance; it may dismiss them. It must not be thought that I am suggesting that training, appraisal and guidance are not required; they are. But nor must it be thought that there is any separation of functions just because the panellists are not members of the GMC. The GMC cannot control the outcome in a particular case, although, as I have said, it will 'advise' a panel chairman when it considers that a FTP panel has erred. Also, as I shall later explain, it has indicated, in recent draft Guidance, that it intends to inform doctors whose cases are referred to a FTP panel what outcome it is seeking in their cases; thus, it would appear, the GMC hopes to be able to influence the way in which the case is dealt with (or at least the sanction which is to be imposed) by the FTP panel.

25.39 Furthermore, it appears that at least some GMC members would have liked to retain an even more substantial degree of control over the outcome of individual cases. At a meeting of the Council in May 2004, it was proposed that the GMC should (subject to further work and consultation) request further legislation to introduce a system whereby the GMC had to ratify decisions of its FTP panels before those decisions came into effect. It was explained that the object was to give the GMC the opportunity to intervene when it regarded a decision as **'clearly perverse'**, to reject the decision and to refer the case to another FTP panel for re-hearing. The proposal was supported by the President, and

Mr Scott spoke in its favour. A number of Council members pointed out that a system whereby the GMC could, within its own procedures, ratify or reject a decision of a FTP panel would be entirely inconsistent with the concept of separation of the investigation and adjudication functions. In the event, the proposal was abandoned and a decision was made instead to seek legislation enabling the GMC to appeal to the High Court against decisions of its FTP panels. However, the mere fact that a system of ratification could have been given serious consideration demonstrates that some within the GMC do not appear fully to understand the concept of separation of the two functions.

25.40 I have a further concern about the position of FTP panellists. Adjudication is a skill which needs regular practice. It is sometimes said that a judge or tribunal member is 'as good as how often s/he sits'. I am concerned that panellists may sit for as little as 20 days a year. They will have little opportunity to develop real expertise. Also, the fact that there will be 200 or more panellists at any one time means that there are likely to be real problems with ensuring consistency of decision-making. It has occurred to me that other healthcare regulators must also have to appoint and train panellists for their FTP procedures. I have wondered whether it might be feasible to appoint a body of full-time or nearly full-time panellists who could sit on panels of all the healthcare regulatory bodies. This would provide a measure of independence from any one particular body, such as the GMC, and would also ensure that panellists developed experience and expertise.

The Tests to Be Applied

The Concept of Impairment of Fitness to Practise

25.41 One of the GMC's main objectives in introducing its new procedures has been to leave behind the compartmentalised approach that had developed under the old procedures for historical reasons. The conduct procedures were the foundation of the GMC's disciplinary processes. The health procedures and the performance procedures were added in 1980 and 1997, respectively. Although it was possible, in some circumstances, for a doctor to be transferred from one set of procedures to another, a case could not be handled within more than one set of procedures at any one time. Understandably, the GMC wanted to overcome this difficulty. The solution it arrived at was to adopt the concept of 'impairment of fitness to practise' as a doctor. This concept, which, as I have said, is embodied in the 1983 Act, forms the foundation of the tests to be applied by decision-makers at both stages of the GMC's new procedures.

Definition of the Term

25.42 The advantage of the concept of 'impairment of fitness to practise' is that it is capable of embracing any or all of the types of problem that the GMC habitually encounters, i.e. misconduct (including breaches of the criminal law leading to convictions or cautions), deficient professional performance, adverse health and determinations.

25.43 The disadvantage of the concept is that it is not at all clear what it means. The concept is not defined in the 1983 Act or in the Rules which are to govern the operation of the new procedures. The only relevant legislative provision is at section 35C of the 1983 Act, where

it is said that a doctor's fitness to practise shall be regarded as 'impaired' by reason only of misconduct, deficient professional performance, a conviction or caution, adverse physical or mental health or a determination. That section imposes a limitation upon the routes by which a doctor's fitness to practise might be found to be impaired, but it does not help in understanding what an impairment of fitness to practise is. I have said elsewhere in this Report that the expressions 'serious professional misconduct' (SPM) and 'seriously deficient performance' (SDP) were difficult to define or even to recognise. I believe that even greater difficulty will be encountered with 'impairment of fitness to practise' unless it is clearly defined.

25.44 The question whether a doctor is fit to practise as a doctor may mean many different things in different contexts. If a doctor is suffering from ill health (for example, severe depression), one might say that s/he is not fit to practise because his/her concentration is so affected that s/he cannot make effective decisions on diagnosis and treatment; s/he presents a risk to patients. If a doctor's performance is found to be deficient (for example, because s/he has 'botched' one or more operations), one might say that s/he is not fit to practise because s/he cannot provide an adequate standard of care to patients and exposes them to risk of harm. If a doctor has been found guilty of offences of indecency, one might say that s/he is not fit to practise because there is a risk that s/he will act indecently towards patients. If a doctor is found guilty of an insurance fraud, one might say that s/he is unfit to practise because s/he is a disgrace to the profession and has brought it into disrepute. Similar considerations might apply to the doctor found guilty of causing death by dangerous driving while drunk. In either of the last two cases, the doctor might be first class so far as his/her clinical practice is concerned. If a doctor has forged prescriptions to obtain controlled drugs for his/her own use, one might say that s/he is unfit to practise because s/he might at any time be under the influence of drugs and unable to make sensible decisions about diagnosis and treatment and/or because s/he is dishonest and cannot be trusted. If a doctor were to give private information to a newspaper about a patient who was a well-known personality, one might say that the doctor was not fit to practise because s/he had breached confidentiality, one of the fundamental tenets of the profession. Another such tenet is the requirement that patients should consent to treatment. A doctor who conducted a research project without obtaining the informed consent of the patients might be said to be unfit to practise.

25.45 The examples I have given are cases where the conclusion might well be that the doctor is completely unfit to practise. However, the concept of an 'impairment' of fitness to practise introduces a difficulty. One dictionary definition of 'impairment' is 'damaged; injured; made less effective; devalued'. Doctors usually use the word in connection with an impairment of function, for example, impaired hearing or impaired mobility. In those contexts it simply means 'reduction'. Some of the ways by which 'impairment of fitness to practise' may be demonstrated under section 35C lend themselves easily to the concept of impairment in the sense of 'reduced'. For example, if a doctor's performance is deficient, one might well say that his/her fitness to practise is 'impaired'. The concept of 'impairment of fitness to practise' may also be quite apposite in cases of ill health. But, in most cases of misconduct and convictions, 'impairment of fitness to practise' is not a helpful concept. For example, if a doctor has been found guilty of the theft of a pair of

shoes from a shop, s/he has been found to be dishonest. Some might say that this has nothing to do with his/her fitness to practise medicine. Others might say that s/he is a disgrace to the profession and is completely unfit to practise. The one thing that you could not sensibly say is that his/her fitness to practise medicine is 'impaired'. I take another example, this time involving clinical practice. If a doctor has been found to have falsified medical records, some might say that s/he is unfit to practise because s/he cannot be trusted. Some might say that s/he is a disgrace to the profession. Others might take a less serious view and observe that, although this kind of behaviour is to be deprecated, it does not affect the doctor's fitness to practise. Although different people might take differing views about the seriousness and relevance of the misconduct, I do not think that anyone would think of saying that the doctor's fitness to practise was 'impaired'.

25.46 So, although I can well understand why the GMC has adopted the all-embracing concept of 'impairment of fitness to practise', and although I recognise its major advantage, it does have disadvantages. It is not easy to define; it means different things in different circumstances and, in some circumstances, it is almost without meaning. Some concepts are difficult to define but relatively easy to recognise when found. It is often said that elephants fall into this category but I have never understood why; definition cannot be too difficult. However, I fear that an 'impairment of fitness to practise' will be not only difficult to define but also not easy to recognise, because (unlike recognising an elephant) recognising 'impaired fitness to practise' involves making a value judgement.

25.47 Even in cases in which the concept of 'impairment of fitness to practise' is obviously appropriate, such as cases of ill health or deficient performance, it will not be every slight impairment that gives rise to the need for intervention by the GMC. If there are gradations of impairment, what level will justify the referring of a case through the procedural stages and at what level will action on registration be justified? All those involved in the FTP procedures will know that not every impairment of fitness to practise will justify action by the GMC. To take an extreme example, one might say that if a doctor goes to work suffering from a headache, his/her fitness to practise may be impaired but no one is going to suggest that the GMC should intervene. The GMC can provide guidance for its staff, case examiners and panellists, but how is the public to understand why a decision was taken and how can the courts decide whether a decision was reasonable if the test is as amorphous as 'impairment of fitness to practise'? There is, in my view, a need for a test which the public understands and by which the courts can judge whether a decision was lawful in the sense of complying with the test.

25.48 Another potential problem arises with the time when fitness to practise is measured or assessed. The 1983 Act permits a FTP panel to take action on registration if it finds that the doctor's fitness to practise is impaired. That implies that the impairment must be present at the time of the hearing. So, if a doctor has committed a serious act of misconduct a year ago, does that indicate that his/her fitness to practise is currently impaired? I understand that the GMC has been advised that, although section 35D(2) of the 1983 Act refers to a finding that a doctor's fitness to practise is impaired, present impairment of fitness to practise can be founded on past matters. That seems sensible. The doctor's current fitness to practise must be gauged partly by his/her past conduct or performance. It must also be judged by reference to how s/he is likely to behave or perform in the future. Having

said that, I think that there will be arguments about the extent to which a past (serious) misdemeanour makes a doctor's fitness to practise impaired at the present time. It would be most unsatisfactory if a doctor was able, by delaying the hearing of a case, to reduce the risk of a finding that his/her fitness to practise was impaired.

25.49 I have made these observations about the concept of 'impairment of fitness to practise', not because I am going to suggest that the GMC should abandon it but to draw attention to some of the problems of decision-making that will be inherent in the new procedures and which, I think, the GMC must take steps to resolve.

25.50 I think it will be helpful, in the resolution of the problems that I am about to outline, if I analyse the reasons why a decision-maker might conclude that a doctor is unfit to practise or that his/her fitness to practise is impaired. In the examples I discussed above, four reasons for unfitness recurred. They were (a) that the doctor presented a risk to patients, (b) that the doctor had brought the profession into disrepute, (c) that the doctor had breached one of the fundamental tenets of the profession and (d) that the doctor's integrity could not be relied upon. Lack of integrity might or might not involve a risk to patients. It might or might not bring the profession into disrepute. It might be regarded as a fundamental tenet of the profession. I think it right to include it as a separate reason why a doctor might be regarded as unfit to practise, because it is relevant even when it arises in a way that is quite unrelated to the doctor's work as a doctor.

The Investigation Stage Test

25.51 The new FTP procedures will begin with the receipt of an allegation. Allegations will be sifted by GMC staff and not all will be referred into the investigation stage. I shall consider that sifting process later in this Chapter. If an allegation survives the preliminary sift, it will be referred (except in the case of some convictions) to case examiners. It is convenient at this stage to discuss the test that the case examiners (and, when the case examiners cannot agree, the IC) will apply at the conclusion of the investigation stage in deciding whether to refer a case to a FTP panel.

25.52 Section 35C(4) of the 1983 Act provides that the IC shall investigate an allegation and decide whether it should be referred to a FTP panel. The section does not specify what test should be applied at that stage. Nor do the November 2004 Rules or any of the drafts which preceded them. This is surprising because it was the lack of a clear straightforward test that gave rise to problems under the old procedures. The problems were lack of clarity about which cases should go through the various filtering processes, and inconsistency of decisions. If the new procedures are to be transparent and are to produce consistent decisions, there should be a clear statutory test for each stage of the process. If there is not, there will be a danger that cases may be filtered out that ought to go forward. If that happens, patients are not adequately protected.

25.53 The test which the GMC has decided should be applied at the end of the investigation stage is whether there is a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration. Action on registration means erasure, suspension or the imposition of conditions upon the doctor's right to practise.

25.54 In the course of the Inquiry hearings, I expressed some concern that the test to be applied by those making decisions at various stages of the FTP procedures made no mention of the protection of patients. It seemed to me that the test focussed exclusively on the sanction to be applied to the doctor and not at all upon the nature and gravity of his/her actions or their effect upon patients. In an apparent attempt to meet those concerns, the GMC added a preamble to the investigation stage test, which appears in various guidance documents:

> **'The Investigation Committee or case examiners must have in mind the GMC's duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration.'**

What I actually had in mind was a test that incorporated the protection of patients as an integral part of the test.

25.55 In any event, the investigation stage test as presently formulated seems to me to give rise to a number of problems.

A Problem of Principle

25.56 As a matter of principle, in any legal process, if there is to be a preliminary process which seeks to filter out cases which should not go through to final adjudication, the test applied to that process should have the effect of filtering out only those cases which, taken at their highest, could not satisfy the test to be imposed at the final stage. In a disciplinary process, the preliminary process should, as a matter of principle, filter out only those cases that, taken at their highest, cannot satisfy the test for disciplinary action.

25.57 The test for disciplinary action under the 1983 Act is whether the practitioner's fitness to practise is impaired. If it is, the FTP panel has jurisdiction to take action on registration. As a matter of principle, therefore, the preliminary screening process should allow through any case in which it is possible (or, if it is preferred, realistically possible) for there to be a finding of impairment to practise. Because 'impairment of fitness to practise' is so imprecise a concept, that screening test would set a very low threshold and would result in a lot of very minor cases being referred through to a FTP panel. I think it must have been in order to avoid that result that the GMC set the investigation stage test at a much higher threshold. It will allow through only those cases in which there is a realistic prospect of a finding of impairment sufficient to justify action on registration.

25.58 I can understand why the GMC would wish to set this higher threshold. It is in no one's interest to have a lot of trivial cases going through to a FTP panel hearing, at the end of which there is no possibility of action being taken on registration. But, in attempting to do this, the GMC has, in my view, created problems of construction and of circularity of definition which deprive the investigation stage test of clarity and which will result in lack of transparency of decision-making.

A Problem of Construction

25.59 The test as currently stated poses a problem of construction. Does it mean:

(a) that the decision-maker has to decide whether, in his/her opinion, what is alleged, if proved, shows that the doctor's fitness to practise is impaired to a degree justifying action on registration and that the evidence available is such that there is a realistic prospect of proving what is alleged; or

(b) that the decision-maker has to decide whether there is a realistic prospect that a FTP panel will find that what is alleged shows that the doctor's fitness to practise is impaired to a degree justifying action on registration and also whether the evidence available is such that there is a realistic prospect of proving what is alleged?

25.60 At the moment, the test does not distinguish between these two possibilities. It is not clear whether the decision-maker is supposed to make a personal judgement about the gravity of the matters alleged or whether the process is one of assessing what the view of a FTP panel might be. That ought to be clarified. However, in my view, neither is satisfactory because both involve the making of a value judgement (either firsthand or secondhand) about the fitness to practise of the doctor if what is alleged about the doctor is proved. A preliminary decision such as the decision to be made at the end of the investigation stage should involve as little value judgement as possible; it should be based, so far as possible, upon an objectively ascertainable threshold.

The Problem of Circularity

25.61 A further problem with the investigation stage test as currently drafted is that it is circular. The case examiner or IC must make a judgement about whether the matters alleged appear to show an impairment of fitness to practise such as would justify action on registration. So, for example, in a case involving an allegation of misconduct, the test involves consideration of whether what the doctor appears to have done is serious enough to justify action on registration. That question immediately prompts a second question, namely: how serious does what s/he has done have to be before it is serious enough to justify action on registration? And the only answer available to that second question is that it has to be serious enough to justify action on registration. We have come full circle. There is no benchmark, no objective standard. The answer to 'how serious does it have to be?' involves a purely subjective judgement by the decision-maker. I accept, of course, that some element of discretionary judgement will always be required in decisions of this kind; decision-makers often have to decide upon which side of a threshold a particular case falls. The problem here is that there are no thresholds. This means that decisions at the investigation stage can never be adequately tested. The decision-making process can never be transparent.

What Should Be Done?

25.62 I suggest that the GMC should think again about the investigation stage test. Because I recognise that it is easy to criticise the work of others and less easy to suggest better ways of doing things, I have tried to devise a test that will be clear and will depend, not upon

an open-ended value judgement (whether at firsthand or secondhand), but upon some more objective criteria.

25.63 The test I propose has two stages. The object of the first stage of the test will be for the decision-maker to decide whether the allegation, if proved, might show that the doctor's fitness to practise is impaired. At the second stage, s/he will have to consider the adequacy of the evidence. At the first stage, I have related 'impairment of fitness to practise' to the underlying reasons why the doctor's fitness to practise might be impaired, which I identified earlier. These reasons are that s/he is a risk to patients, that s/he has brought the profession into disrepute, that s/he has breached one of the fundamental tenets of the profession or that his/her integrity cannot be relied upon. Those concepts are far easier to recognise than 'impairment of fitness to practise'. So, the two stages are:

1. Is there one or more than one allegation of misconduct, deficient professional performance or adverse health and/or one or more than one report of a conviction, caution or determination which, if proved or admitted, might show that the doctor:

   (a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

   (b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

   (c) has in the past committed a breach (other than one which is trivial) of one of the fundamental tenets of the medical profession and/or is liable to do so in the future; and/or

   (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.

If so:

2. Is the available evidence such that there is a realistic prospect of proving the allegation?

25.64 I would suggest that a doctor should be regarded as 'liable to' act in a certain way if a reasonable and well-informed person would consider, in the light of what is known about the allegation and about the doctor's past and present circumstances, that there is a real risk that s/he might act in that way. The evidence of a single past event might be serious enough, standing alone, to satisfy the investigation stage test. For example, evidence that a doctor had harmed a patient, as Shipman was believed to have harmed Mrs Renate Overton, by giving her an inappropriate dose of morphine (see Chapter 10), would satisfy the test. Evidence of a less serious error, for example, the kind of prescribing error that Shipman made in the case of Mr W (see Chapter 6), might not be sufficient standing alone, but would be sufficient if coupled with other evidence that suggested that the doctor was liable to make careless mistakes. Evidence of poor communication skills, contained in a performance assessment report, might well pass the test, even if there was no significant past incident in which harm had been caused; it might pass on the basis that the doctor was liable to cause unwarranted harm in the future. I would suggest that 'unwarranted risk of harm' should be defined as a risk of harm over and above that which would be expected to arise from the advice or treatment had it been given or administered with reasonable

skill and care. Insofar as there is no agreement on the fundamental tenets of the medical profession (some of which appear in 'Duties of a Doctor'), a list could be developed and agreed.

25.65 In my view, the application of that two-stage test would give case examiners and the IC something more objective to focus upon than 'impairment of fitness to practise'. It would avoid those people having to 'second guess' the view that the FTP might take about the need to take action on registration and it should also avoid trivial cases being sent through to the FTP panel. Finally, I think also that it would satisfy the public's reasonable expectation about the kind of case that ought to go through to a FTP panel. If correctly applied, it should ensure that all those cases that ought to proceed (for reasons of patient protection) do in fact proceed to a FTP panel.

The Adjudication Stage Test

25.66 At the present time, the test to be applied by the FTP panel is simply framed in the words of the statute. The statutory test is whether or not the doctor's fitness to practise is impaired. It is not, as the GMC's Guidance to Panellists suggests, whether or not the doctor's fitness to practise is impaired to a degree justifying action on registration. I suspect that FTP panels will have great difficulty in applying the statutory test in a consistent way. The test requires a value judgement that is not underpinned by any objective criteria. Nowadays, where a statute gives a decision-maker a discretion, it usually provides a list of the kind of things that should be taken into account.

25.67 In devising an adjudication stage test (to be applied by FTP panels under Rule 17(2)(k)), I have tried to focus the panel's mind on its true purpose. I suggest that:

> Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> (a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> (b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> (c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
>
> (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.

25.68 If the FTP panel finds that the doctor's fitness to practise is impaired, it should go on to consider sanction under Rule 17(2)(n). It is at this stage (and not before) that the statutory scheme requires the FTP panel to consider whether the doctor's fitness to practise is impaired to a degree justifying action on registration. At this stage, I suggest that the panel asks itself:

> Would a reasonable and well-informed member of the public conclude that the doctor's fitness to practise is impaired to the extent that, in the interests of patient

protection and/or of the maintenance of public confidence and of standards in the medical profession, the doctor's registration should be erased or suspended or have conditions imposed upon it?

In a case which depends wholly or mainly on findings in relation to the doctor's ill health, erasure will not be available. I have incorporated into the second limb of the test the view that would be taken by an informed member of the public because I am firmly of the view that the standards, criteria and thresholds that are to be applied by FTP panels must be acceptable to society as a whole. That they have not been in the past has been one of the major causes for public criticism and lack of confidence in the GMC.

25.69 I hope that the GMC will give serious consideration to these proposed tests. When a final decision has been taken, the tests for both the investigation and the adjudication stages should be enshrined in legislation. There are several reasons why this should be done. The GMC should be able to say that the tests to be applied have been sanctioned by Parliament. The public should know that the GMC is applying the law of the land and not just a formula of its own making. It should not be possible for the GMC to change the tests to be applied without proper consultation and without the approval of Parliament. Furthermore, it is important that there should be statutory tests by reference to which the courts can examine any decision, whether on judicial review in respect of the investigation stage decision or on appeal from the decision of a FTP panel.

Section 35C of the Medical Act 1983 and the Ways of Proving Impairment

25.70 It will be seen that, in drafting the tests that I have proposed for the investigation and adjudication stages, I have adopted the five categories of allegation by means of which, under section 35C of the 1983 Act, an impairment of fitness to practise may be demonstrated. However, in my view, there is a *lacuna* in these five categories. There is a category of allegation which does not fall easily within the range of 'deficient professional performance' or of 'misconduct'. Misconduct, as I explained in Chapter 17, generally connotes behaviour which has been undertaken deliberately or recklessly. In order to give the GMC jurisdiction to deal with cases of serious negligence which put patients at risk, the bounds of SPM were extended to embrace negligent acts or omissions, usually arising in a clinical context, provided that they were sufficiently serious. However, to describe some of these cases as 'misconduct' required some 'stretching' of the use of the language. A typical example might be that of a doctor who gave a gross overdose of a dangerous drug. He or she might have done so because s/he was very careless about the size of ampoule s/he picked up or because s/he had not bothered to find out the correct dosage. Another example might be operating on the wrong arm, leg or kidney. Such cases of serious negligence might equally well – or even more appropriately – be described as cases of 'deficient clinical practice'. With the advent of the performance procedures came the concept of SDP. This was usually characterised by a pattern of unacceptable clinical practice, although it could relate to organisational or behavioural problems. Such a pattern might result from ignorance, from a failure to keep up to date, from laziness, from poor health or from a concatenation of social or professional difficulties. So, there were then two concepts, SPM and SDP, neither of which comfortably accommodated a case of serious negligence such as that

I described above. Such a case could not sensibly be termed SPM; nor, if it was a 'one-off' incident, could it possibly amount to SDP. Under the old procedures, there was a real danger that such cases would fall through the net and would be closed at a preliminary stage.

25.71 Unfortunately, section 35C has perpetuated this problem. There is still no place for the isolated or nearly isolated serious error, committed not deliberately or recklessly, but negligently. Nor is there a place for a case of two or three 'lower level' incidents which do not demonstrate the 'pattern' necessary to constitute deficient performance but which may nonetheless put patients at risk. It seems to me to be obvious that such cases ought to enter the FTP procedures because they could be cases of impairment of fitness to practise. I suggest that, if the legislation is to be amended, a further category should be added to the means by which impairment may be proved, namely 'deficient clinical practice', which could relate to one or more than one incident. The aim would be to ensure that the 'routes' to impairment of fitness to practise embrace all the circumstances which might put patients at risk.

25.72 So far in this Chapter, I have discussed the broad issues relating to the new procedures. I have made certain suggestions for change. I shall now move on to consider, in some detail, the provisions under which the new procedures will operate in the immediate future.

The Roles of the Investigation Committee and of the Case Examiners

25.73 Before describing the various processes comprised within the investigation stage, I shall first explain the roles currently envisaged for the IC and the case examiners. This will also involve a discussion about the GMC's intentions with regard to the involvement of lay people in decisions made at the investigation stage.

The Investigation Committee

The Functions and Composition of the Investigation Committee: the 2003 Position

25.74 The new section 35C(4) of the 1983 Act requires the IC to investigate every allegation made to the GMC that a doctor's fitness to practise is impaired. However, it was never intended that the IC should itself make the decision about how to deal with the allegation in every case. Section 35CC of the 1983 Act, therefore, provides that Rules may be made, enabling the Registrar (in practice, members of the GMC staff exercising his legal powers) or any other officer of the GMC (in practice, the new case examiners) to exercise the functions of the IC, whether generally or in relation to such classes of case as may be specified in the Rules.

25.75 Until very recently, the GMC had intended that the IC should play a pivotal role in the investigation stage, not only in the making of decisions in relation to individual cases (its 'casework function'), but also in the supervision and management of the investigation stage as a whole (its 'governance function').

25.76 At a meeting held in October 2003, the Council considered a briefing paper dealing with the proposals for the purpose, functions, structure and membership of the new IC. These

proposals were said to be subject to the general review of the role of GMC committees and their working methods which was then going on. At the meeting, the Council took the formal decision that the IC should perform both a governance function and a casework function. It was also decided that the IC should be composed of nine members of the GMC who would volunteer for membership. An election would take place only if there were more volunteers than places. The intention was that the nine members would discharge the IC's governance function. It was also plainly envisaged that some (if not all) of the nine members of the IC would sit on IC panels to deal with decision-making in individual cases. It was proposed that the IC should have the power, where necessary, to co-opt additional panellists from the list of trained panellists who had been appointed by the GMC. In other words, it was proposed that decision-making on individual cases was to be undertaken by a mixture of GMC members and non-members. The IC's governance function would be exercised exclusively by GMC members. There would be an overlap of IC members performing both functions. It seems from the minutes of the meeting that these proposals were accepted in principle.

25.77 The IC's governance function was to involve overseeing the investigation stage and defining the criteria to be applied by case examiners, GMC staff and IC panels when making decisions in individual cases. The IC was also to review all aspects of the decisions made at the investigation stage and was to put in place and supervise an appropriate quality assurance and audit process. It was to agree service standards for the processing of cases and was to review and monitor performance against those standards. It was to review the numbers and types of cases dealt with at the investigation stage and to ensure that the relevant processes were working effectively and efficiently. It was to report regularly to the Council on the operation of the investigation stage.

25.78 It was originally intended that, as part of its governance function, the IC should have the power to decide on the extent to which it was appropriate to delegate its casework function to case examiners and to other GMC staff. The 2003 draft Rules provided that decisions about how an individual case should be dealt with could be taken either by the IC or by case examiners. The intention was that the IC would decide the extent to which it was prepared to delegate its decision-making powers at any given time. The expectation was that it would begin by delegating only a limited range of decisions to case examiners but that, over time, the extent of delegation would increase as the IC gained confidence in the abilities of the case examiners to take appropriate decisions. However, it was agreed at the October 2003 meeting that the delegation of casework should **'develop quickly'**.

25.79 At the time of the Council meeting in October 2003, it was not clear to what extent case examiners would be authorised to take decisions in individual cases. A briefing paper presented to the Council at that meeting suggested that **'a minimum starting position'** should be that decisions that had not required the involvement of the PPC under the old procedures should not require the involvement of the IC under the new procedures. The briefing paper referred to the **'clear advantages'** of delegating decision-making to case examiners in **'the vast majority of cases'**. It plainly contemplated that most decision-making would be done by individual case examiners. The briefing paper went on:

> **'It would deliver efficiency and flexibility and would help to meet one of the key themes of the Fitness to Practise review – streamlining and speeding-up the process. It would also limit the resources required to service a fully functioning casework committee. The Committee** (*i.e. the IC*) **would set the protocols and policy for making decisions on cases and would monitor and review the outcomes on cases.'**

25.80 Under the arrangements envisaged in October 2003, the IC's power would have been formidable, given the supervisory role that it was intended the IC should have and the fact that it was to be responsible for setting the criteria for decision-making within the whole of the investigation stage. It would also have had the power to decide which cases or types of case it was prepared to delegate to case examiners and which it preferred to keep exclusively within its own control.

The Functions and Composition of the Investigation Committee: the 2004 Position

25.81 I have described above the proposals for the functions and composition of the IC that were current at the conclusion of the Inquiry's hearings in December 2003. However, by the middle of 2004, those proposals had changed completely. The GMC received legal advice to the effect that, under section 35CC(1) of the 1983 Act, it is the Council itself – not the IC – which has the power to delegate the IC's decision-making functions to case examiners and other staff. Furthermore, the precise extent of the delegation should, so the GMC was advised, be set out in the relevant Rules. In the event, having considered the matter, the GMC found it impossible to identify for inclusion in the Rules any specific classes of case in which it considered that responsibility for decision-making could be delegated by the Council to case examiners.

25.82 As a result, the GMC revised the arrangements for the investigation stage. It decided that case examiners should be given specific powers by the Rules to take decisions in the majority of cases. It decided that the decision-making role of the IC should be confined to only two types of case, i.e. those where the case examiners disagreed and those in which it was necessary to hold an oral hearing in order to decide whether to issue a warning. I will discuss these types of case later in this chapter. As a consequence, the likely caseload of the IC was reduced. The proposed reduction in the IC's casework function in turn led to a reconsideration of its composition and proposed governance function. At the July 2004 Council meeting, the Fitness to Practise Committee made recommendations to the Council about these matters.

25.83 The Fitness to Practise Committee proposed that the IC should have no governance role and that responsibility for overseeing the investigation stage should instead devolve to the Fitness to Practise Committee itself. It proposed that the IC should be constituted as a casework committee only. Under these proposed new arrangements, the IC would not, as had previously been intended, have a static membership of nine GMC members. Instead, it would consist solely of panels which would have a 'floating membership'. Panels would be convened specifically to make decisions in individual cases. It was proposed that the panels should be drawn primarily from a pool of GMC members who would volunteer for the purpose. Those GMC members would have to undergo training and assessment.

Associates would also be co-opted to sit on IC panels as and when necessary. In order to preserve the separation of functions, it was proposed that those persons who were selected and appointed to sit as panellists should be required to opt to sit on either IC panels or FTP panels; they would not be permitted to sit on both.

25.84 The Fitness to Practise Committee considered that, in view of the IC's involvement with casework, it would be inappropriate for it to undertake any audit or review of decisions in individual cases. It proposed, therefore, that audit and review should be undertaken by the Fitness to Practise Committee. The Fitness to Practise Committee would then have an overarching responsibility for co-ordinating and monitoring the operation of both the investigation and the adjudication stages of the new procedures. That idea seems also to raise a problem of separation of functions. The description of the first model for separating the investigation and adjudication functions set out in the 2001 Consultation Paper had specifically provided for the investigation and adjudication stages to have separate arrangements for **'reporting and accountability'**: see paragraph 25.29.

25.85 The Fitness to Practise Committee outlined an alternative arrangement, whereby the IC would retain a static membership of GMC members who would be responsible for governance of the investigation stage (including audit and review of decisions), but who would delegate casework to panels of associates. However, its preference was for the model I have previously described.

25.86 When the proposals put forward by the Fitness to Practise Committee were discussed by the Council at its July 2004 meeting, there was considerable difference of opinion among those present. It was said that the IC (which is established by statute) was being 'downgraded' into 'just a casework committee', while the Fitness to Practise Committee (which is not a statutory committee) took over the governance functions which it had always been intended that the IC should undertake. A number of Council members supported a suggestion that, far from losing its governance role, the IC should assume entire responsibility for the supervision of the new FTP procedures (i.e. governance of both the investigation and the adjudication stages), with the current Fitness to Practise Committee becoming redundant. This would, of course, have the effect of extending the role of the IC well beyond that which had originally been envisaged for it. Other Council members pointed out that to give to the IC, which has a statutory responsibility for casework at the investigation stage, a supervisory role over the FTP panels responsible for decision-making at the adjudication stage would completely negate the principle of separation of functions. Nevertheless, some Council members advocated this solution. An alternative view was that the IC should retain, in addition to its casework function, a limited governance role involving responsibility for auditing and training case examiners.

25.87 The Fitness to Practise Committee also expressed the view that membership of the Fitness to Practise Committee and of IC panels should be mutually exclusive, because of the potential conflict of interests that might arise if the same individual were involved with the making of decisions in individual cases and with the audit and quality assurance of those decisions. Some Council members agreed with this view and expressed reservations about the principle of having Council members involved both in casework (as members of IC panels) and in a governance role (as members of the Fitness to Practise Committee).

It was suggested that it would be more appropriate for IC casework to be undertaken only by associates. There was, however, no agreement about this matter.

25.88 The debate did, however, result in a limited amount of agreement. The minute recording that agreement states:

> **'Fitness to Practise: Investigation Committe**
>
> **11. Council agreed that there should be three groups of functions, namely:**
>
> **a. Policy, audit, oversight and other governance functions, covering both investigation and adjudication.**
>
> **b. Investigation casework.**
>
> **c. Adjudication casework.**
>
> **12. The aim was to have a single committee with governance responsibilities, overseeing investigation casework and adjudication casework. For both investigation casework and adjudication casework, group decision making and hearings should be undertaken by panels. Council recognised that the aim of a single committee could not be achieved within the law as it stood. Until the Medical Act 1983 could be amended, responsibilities should be:**
>
> **a. Policy, audit and oversight – Fitness to Practise Committee**
>
> **b. Investigation casework – Investigation Committee (meeting as panes) and case examiners.**
>
> **c. Adjudication casework – fitness to practise panels and interim orders panels.'**

25.89 For the present, the General Medical Council (Constitution of Panels and Investigation Committee) Rules 2004 (the Constitution Rules 2004) provide that membership of the IC shall comprise medical and lay panellists (including at least one person taken from the list of panellists eligible to sit as Chairman of a panel) selected by the Registrar to sit on a particular occasion. Members of the GMC may act as IC panellists. The IC will have no static membership. The legal quorum for an IC panel will be three, comprising the Chairman (who may be medically qualified or lay), together with one medical and one lay panellist.

25.90 It is not clear whether the IC will ultimately assume the functions of the **'single committee'** referred to in the minute. No agreement about that was reached at the July 2004 Council meeting. Nor was any decision reached on the issue of whether IC panels would be composed of a mixture of GMC members and associates, or only of associates. A recent letter written by the GMC to the Inquiry stated that, although the November 2004 Rules permit Council members to sit on IC panels, the **'operational intention'** is for the panels to be composed of appointed associates. It is not clear whose **'operational intention'** this is, since there does not appear to have been any Council decision to this effect.

Comment

25.91 These late changes to the new procedures appear to have been forced upon the GMC as the result of its failure to understand the effect of the amending legislation which it had asked for. This gives the impression that the GMC had not given sufficient thought to how the new procedures were to work before it asked for legislation to be drafted.

25.92 The original proposals would have given rise to an unsatisfactory position. The IC would have been enormously powerful. Not only would it have been responsible for the policy of the investigation stage decisions, including standard-setting, it would itself have made many of the casework decisions and would have been responsible for the supervision of the case examiners and the audit of all investigation stage decisions. Self-audit is not acceptable, as has now apparently been recognised.

25.93 For the moment, it appears that the powers of the IC will be limited to taking decisions on individual cases. The functions of governance, supervision, audit, standard-setting and the issuing of guidance to staff and case examiners in respect of the investigation stage will be passed to the Fitness to Practise Committee. It will place a very considerable burden on that Committee but at least – for the time being – the functions of decision-making and governance will be separated.

25.94 At present, it is not clear what the GMC's ultimate intention is. At the meeting in July 2004, it was suggested that the IC should have responsibility for the adjudication stage. I do not think that that is now intended, although there were some GMC members who thought it appropriate. The position for the future is not entirely clear and this degree of uncertainty at a time when the new procedures are actually coming into effect is unfortunate.

25.95 In my view, the functions of the IC should be, as they apparently will be in the immediate future, limited to casework. It is not appropriate that any committee should have total responsibility for all aspects of the investigation stage of the FTP procedures, even down to auditing its own decisions. To give one small committee complete control of the whole investigation stage carries risks. However, it is equally unsatisfactory for one committee to have control of the governance of the investigation stage and the adjudication stage, as was recognised in the 2001 Consultation Paper. I realise that this might give rise to difficulties for the new GMC with only 35 members.

25.96 At present, it appears to be the intention that, after amendment of the 1983 Act, one committee will have responsibility for the governance of both the investigation and adjudication stages. It appears that the Fitness to Practise Committee considers that, if two committees are involved in governance of the different stages, there will be confusion and inconsistency. I can see that it is desirable that the same group of people should set the standards, criteria and thresholds applicable to both stages; these must be compatible. However, it seems to me that the supervision and audit of the two stages should be separate, first because the power of the single committee over the whole process would be too great – some checks and balances are desirable – and, second, because the GMC claims that it wishes to maintain some separation between the investigation and adjudication functions.

Case Examiners

25.97 The introduction of case examiners is an integral feature of the new procedures. In 2003, the GMC appointed five people (three medically qualified and two lay) to fulfil the role of case examiners. Further case examiners have been appointed subsequently and the GMC has advertised for more. When the first case examiners were appointed, it was expected that the new procedures would be in place by the spring of 2004. In March 2004, when it had become clear that the introduction of the new procedures was going to be delayed, the GMC appointed the case examiners to act as screeners for conduct and performance cases under the old procedures. In addition, two of the medically qualified case examiners were appointed to act as health screeners and two were appointed to act as performance case co-ordinators. These arrangements were to continue until the new FTP procedures came into operation. The appointment of the case examiners as screeners was made subject to the case examiners being mentored by existing screeners and subject to 100% of their work being audited by GMC staff. It was expected that, by the end of June 2004, the previous screeners would have ceased to carry out their screening duties and that the case examiners would have assumed total responsibility for screening.

25.98 The case examiners are contracted to work for the GMC for a minimum of eight days a month and, when working, are based at the GMC's offices. They will be trained, directed and appraised by the GMC and, as I have said, their work will be subject to audit. During the selection process, considerable emphasis was placed on the need for analytical abilities, for a capacity to undertake high level decision-making and for an ability to exercise impartial and independent judgement. Medically qualified candidates were required to have been in active practice within the last three years and to be **'participating in revalidation'**. The job specification for case examiners stated that they should have the **'ability to carry out an investigatory appraisal to establish facts'**.

Comment

25.99 It seems to me that there are a number of potential advantages attaching to the appointment of case examiners to undertake the functions formerly carried out by screeners. First, the case examiners will be working in dedicated time. Screeners had to fit their GMC duties into the interstices of days already occupied with a busy medical practice or a demanding job. Also, because the work will be done at the GMC's premises, there should be much closer communication between case examiners and staff and between case examiners. Screeners worked from home and communication was less easy. Case examiners will be employed by the GMC and can be required to carry out their duties in a particular way. They could, for example, be given instructions that all cases of a certain category must be referred to a FTP panel. This was not possible with screeners; they were members of the GMC and could not be required to conform to instructions. I described in Chapter 19 the way in which some medical screeners sabotaged the GMC's efforts to encourage consistency of treatment at the screening stage by creating categories of misconduct which would be 'SPM by definition' and which should automatically have been referred by screeners to the PPC. It seems that the screeners persuaded members of staff to change the standard documents so as to circumvent the

system that had been agreed. It seems highly unlikely that employed case examiners would be able to do that and, if they did, they would be at risk of disciplinary action. Another advantage is that case examiners will have only one set of functions. Screeners had often had experience of sitting on the PPC or the PCC in the past and it seems that they were sometimes unwilling or unable to confine themselves to their screening role.

25.100 The only potential disadvantage of the use of case examiners appears to be that there is a danger that they might be insufficiently independent; they might be too closely directed by GMC members or committees and might not be permitted to use their professional judgement. Also, they might have too little 'say' in how a case is investigated. I hope that these problems will not occur, as the appointment of case examiners provides potential for real improvement over the old procedures. It is essential that standards and criteria should be set and guidance given but, within those parameters, case examiners should be able to exercise their professional judgement.

Lay Involvement in Decision-Making

The 2003 Proposals

25.101 One striking feature of the 2003 proposals was that they would have allowed a single, medically qualified case examiner to close a case without consultation with – or the agreement of – a lay colleague. That arrangement represented an important departure from the principle – which had been accepted by the GMC in 1990 – that no case which raised a question of SPM (or, from 1997, SDP) should be closed by a medically qualified screener without the agreement of a lay screener. Before the introduction of lay screeners in 1990, there had been concern on the part of many about the lack of lay involvement in the screening process.

25.102 During the initial consultation on the new FTP procedures, concern was expressed about the absence, under the proposals then being considered, of any requirement that a lay person should confirm a preliminary decision to close a case taken by a single medically qualified case examiner. Concern was also expressed by some individuals and organisations that the proposed model would place too much responsibility in the hands of one individual. Despite those concerns, the GMC did not change its position. The FTP Review Group's paper, which was considered by the Council at its November 2001 meeting, pointed out that 'double-handling' of cases (whereby cases which a medically qualified screener had made a preliminary decision to close were also considered by a lay case examiner) would require significant additional resources. It was estimated that case examiners would close 2000 cases a year. The effect of double-handling cases where there had been a preliminary decision to close the case would, it was said, be to produce 2000 extra screener transactions a year and almost to double the number of case examiners required. Case examiners are an expensive resource and the appointment of an increased number of case examiners would represent a significant additional cost to the GMC. It was also suggested that double-handling of cases by case examiners would cause delay. The paper suggested that no decision should be taken on the point at that time. Instead, the FTP Review Group concluded that the **'best approach'** would be not to make a decision about lay involvement then but instead to **'allow the detailed processes**

to evolve with experience'. That suggestion was adopted and the issue was shelved for the time being.

25.103 The GMC's internal paper, 'Review of Fitness to Practise: The New Model', of October 2002 (the version dated 22nd November 2002) did not directly address the issue of lay input into decisions by case examiners to close cases. Instead, it referred to the **'important principle'** that all cases, save those closed by the GMC office staff, should be considered by **'two experienced people'**. The implicit suggestion appeared to be that the objections both to a lack of lay involvement and to the involvement of only one person in the decision-making process could be met by the fact that most cases would be considered by an **'experienced and appropriately senior member of staff'** in addition to a case examiner. The paper proposed that, if the member of staff and the case examiner disagreed, the case should be referred to another case examiner (not necessarily one of the lay case examiners). The paper went on to propose that the IC might wish to **'insist'** that it should see any case where there was disagreement or doubt. These proposed arrangements for cases where a member of staff and a case examiner disagreed about the way to dispose of a case were not set out in the 2003 draft Rules. Nor were they mentioned in the draft Guidance accompanying the 2003 draft Rules or in the draft Guidance for case examiners, 'Investigation Stage Test – Guidance for Case Examiners', produced by the GMC in late 2003 (the 2003 draft Case Examiner Guidance). It seems, in fact, that the arrangements proposed in November 2002 (whereby a case could be referred to the IC for a 'second opinion') had been dropped by that time and that a decision had been taken that a single medically qualified case examiner was to be permitted, in a case delegated by the IC, to take a decision to close a case without first securing the agreement of any other person. Similarly, a single lay case examiner was to be permitted to take a decision without any input from a medically qualified person.

Comment

25.104 I find it depressing to observe that, over the period of more than two years during which the new procedures were being developed, the GMC did not appear to recognise or accept the fundamental requirement for lay involvement in all cases that might be closed without referral to a FTP panel. Of course, one is sympathetic to problems of money and resources but there are some things that are so obviously necessary that they simply have to be done, whatever the cost. First, there was a shelving of the problem and then, a year later, an attempt to find a solution that was plainly unsatisfactory. Later still, that attempt was abandoned and the lack of lay involvement was ignored. Given the GMC's earlier commitment to greater lay involvement, it seems to me extraordinary that the removal of lay input into such important decisions could ever have been contemplated.

25.105 At the Inquiry's hearings in December, Sir Graeme Catto and Mr Scott were asked about the absence of any lay input into a decision by a medically qualified case examiner to close a case. Sir Graeme said that one of the factors which had influenced the decision had been the delay that had in the past been caused by passing cases between different people within the GMC. However, case examiners will be working in the GMC's offices, so it is hard to see why it should have been thought that delay would arise. Sir Graeme also said that it had been thought that case examiners, who would be contracted to work for

the GMC in dedicated time, would be more professional and focussed than the existing screeners, who had to fit in their screening activities between their other commitments. That hardly meets the point that a medically qualified case examiner will bring a medical perspective to the case and that a lay perspective is also needed. Nor does it meet the point that more than one person should be involved in a decision to close a case. However, in the course of their evidence, both Sir Graeme and Mr Scott indicated that the GMC was prepared to look again at the issue. This it has now done and it appears that its members have belatedly recognised that the proposed arrangements were unacceptable and would not have commanded the confidence of the public.

The 2004 Position

25.106 The May 2004 draft Rules provided (as the November 2004 Rules provide) that all cases which survive the preliminary sift by the GMC staff will be considered by two case examiners, one medical and one lay. This is a most welcome move and, in fact, provides greater lay involvement than under the old procedures. The involvement of a second case examiner is not confined to, as previously, cases where a medically qualified case examiner had taken a decision to close the case or was contemplating such a decision. Instead, lay case examiners are to be involved in the consideration of every case that reaches the stage of being referred to a case examiner. Thus, the arrangement has even greater resource implications than the arrangement that had been contemplated in November 2001, when it was thought that the double-handling of the cases where a preliminary decision to close had been taken would almost double the number of case examiners required. If all other aspects of the new FTP procedures had remained the same as had been proposed in 2003, significantly more case examiners would have been needed. However, as I shall explain, changes to other aspects of the new procedures were also introduced in the May 2004 draft Rules (most notably to the arrangements for dealing with cases with a health or performance element and, at the adjudication stage, for preparing cases for review and restoration hearings). These changes appear likely to have the effect of reducing significantly the workload of the case examiners in relation to those aspects.

25.107 The changes in the role of the IC that I have already mentioned will also have a significant impact on the role of the case examiners. Under the November 2004 Rules, a case will be referred to the IC only if the two case examiners who consider it cannot agree or in the event of an oral hearing being necessary before a decision is taken whether or not to issue a warning. As a consequence, in the vast majority of cases (certainly in the vast majority of cases involving allegations of misconduct), the case examiners will take the decision whether or not to refer a case to a FTP panel. The case examiners will, therefore, have a central and most important role.

Comment

25.108 As I have said, the current provision for the involvement of lay case examiners in all decisions (save in those cases closed by staff) provide for much greater lay involvement than under the old procedures. I recognise that the resource implications must be

considerable. In my view, lay involvement in all decisions is likely to result in improved quality of decision-making. My understanding is that the lay case examiners will play a full and equal part in decision-making and that their scrutiny of a case will not necessarily take place after that of the medically qualified case examiner. I hope that that will be so. If a lay person examines a case file in the knowledge that a medical person has already reached the conclusion that the case should be closed, his/her thought processes may be distorted. There is a danger that the lay person will subconsciously defer to the view of the medical person. If the lay person examines the case without any preconceptions, his/her decisions are likely to be of greater value in the drive towards public protection. In my view, this increase in lay involvement is likely to engender a greater degree of public confidence.

The Investigation Stage

25.109 I shall now examine the various processes involved in the investigation stage. In particular, I shall consider the activities undertaken by the GMC staff, by the case examiners and by the IC.

The Purpose of the Investigation Stage

25.110 It is important to note at the outset that, as I have previously explained, the term 'investigation' in this context is not intended to mean a process of evidence gathering. The 'investigation' to be undertaken during the investigation stage of the FTP procedures is the determination of whether a case should be referred to a FTP panel. However, the process of evidence gathering may be one of the activities carried out during the investigation stage.

The Preliminary Sift of Cases by Administrative Staff

25.111 Under the old procedures, members of the GMC staff (exercising the legal powers of the Registrar) carried out an initial filtering exercise. They closed cases that fell into certain categories which had been identified by the GMC as not giving rise to an issue falling within its remit. Under the new procedures, the first step in the process of dealing with allegations reported or referred to the GMC will be a similar initial sifting exercise.

25.112 Under rule 4 of the November 2004 Rules, the staff will be required to refer for consideration by a medical and a lay case examiner an **'allegation'** which they consider **'falls within'** section 35C(2) of the 1983 Act. Section 35C(2), to which I have previously referred, states that:

> **'A person's fitness to practise shall be regarded as ''impaired'' for the purposes of this Act by reason only of –**
>
> **(a) misconduct;**
>
> **(b) deficient professional performance;**
>
> **(c) a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;**

(d) adverse physical or mental health; or

(e) a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect.'

25.113 Whether or not the staff consider that a case **'falls within'** section 35C(2) seems a rather odd 'test' to apply. From the words of the rule itself, it is not clear to what extent the staff are to be required to consider whether the allegation is capable of amounting to an 'impairment'. If they are, the test would impose a much higher threshold than was imposed under the old conduct procedures, when the Registrar (or member of staff) had to refer a case to a medical screener if it raised a question of SPM. If the staff are required only to consider whether the information contains an **'allegation'** of the types listed in sub-paragraphs (a) to (e), the threshold will be similar to that under the old procedures, and would be appropriate.

25.114 The draft Investigation Manual Version 2, dated November 2004 (the November 2004 draft Investigation Manual), produced for the guidance of the GMC staff, shows the intended scope of the Registrar's discretion (or that of the staff exercising his legal powers). A staff member should close a case only on specific grounds. Broadly speaking, the staff members should have concluded that the allegation does not raise a question of any of the factors listed at paragraphs (a) to (e) of section 35C(2) of the 1983 Act.

Comment

25.115 It appears that the GMC intends that the 'test' at this initial stage should be similar to the test under the old procedures. It is to be hoped that a form of words might be found so that the Rules more clearly express the GMC's intention. I suggest that the rule might be amended to state: '... where the Registrar considers that the allegation raises a question whether the doctor has been guilty of misconduct, his/her professional performance has been deficient, s/he has been subject to a conviction, caution or determination or has suffered or is suffering adverse physical or mental health (i.e. the factors listed at paragraphs (a) to (e) of section 35C(2) of the 1983 Act)'. The public would then know what test the GMC was applying at this stage.

The Diversion of Cases to Local Complaints Procedures

25.116 At this point, it is necessary to consider what, if any, steps will be taken by staff at this stage of the new procedures to direct cases into local complaints procedures. In the past, as I explain in Chapter 18, many cases have been closed by GMC staff because the complaint related to treatment under the NHS or in the private sector and it appeared that local complaints procedures either had not been used at all or had not been pursued to their conclusion. Before closing a case and advising a complainant to direct his/her complaint to local complaints procedures, the staff did not consider (as the Rules required them to do) whether the case raised a question of SPM. The GMC staff would advise a complainant

to pursue his/her complaint through local complaints procedures and would close the case, unless the staff had reason to believe that the doctor was dangerous or the complainant insisted on the complaint being considered by the GMC.

25.117 Two concerns arose out of this practice. The first was that it put the onus onto the complainant to take matters forward. Second, the GMC did not follow matters up and seek to find out whether the complaint had been pursued locally; there was therefore a danger that some complaints that might have amounted to SPM were lost to the regulatory system. Those concerns were put to the witnesses from the GMC who gave evidence to the Inquiry. They were asked why the GMC did not take responsibility, in an appropriate case, for passing the case to the relevant complaints body, instead of leaving it to the complainant. They were also asked why the GMC did not follow up such cases to ensure that they were not lost. In evidence to the Inquiry, Sir Graeme Catto said that the issue was 'rising to the top of our (*i.e. the GMC's*) agenda'.

25.118 These issues are not expressly dealt with in the November 2004 Rules, the Guidance accompanying them, the November 2004 draft Investigation Manual or the initial processing and assessment form (IPA). The IPA sets out every step of the investigation stage and, if it were the intention of the GMC to close cases because local procedures had not been exhausted, I would have expected the IPA to identify the stage at which that should be done and to specify the criteria to be applied. The Guidance accompanying the November 2004 Rules states:

> **'... the Registrar may ... advise the maker of the allegation about other means of resolution (such as the NHS complaints procedure) or refer the allegation directly to another body for consideration'**.

25.119 However, the context of this passage suggests that this advice is only to be given if the member of staff has already decided that the case does not fall within the jurisdiction of the GMC. To give such advice in those circumstances would be entirely appropriate. The criteria set out in the IPA for making the decision as to closure seem to me to have been drafted so as to ensure that all matters that do fall within the GMC's jurisdiction are accepted into the system. It looks as though the GMC has accepted that the old practice about which the Inquiry expressed concern is to be discontinued under the new procedures. I recognise that that will lead to an increased workload for the GMC but it is clearly the right decision.

25.120 It might be said that it would be reasonable for the GMC to advise the makers of allegations about the existence of alternative means of resolution even in cases where the allegation did fall within the GMC's jurisdiction. Provided that the maker of the allegation was not put under pressure and freely consented to take his/her allegation to a local NHS body, what could be the harm in that? In my view, it would not be a good idea to offer such advice. At the present time, local NHS complaints procedures are not appropriate for many cases in which patient protection issues arise; for example, there are at present no adequate facilities for investigating a complaint about a general practitioner (GP) at the first stage of the NHS complaints procedures. Now that the Commission for Healthcare Audit and Inspection (known as the Healthcare Commission) is responsible for the second stage,

such facilities are available then, but I do not think it would be right to suggest that a complainant take that route in order for the allegation to be investigated.

25.121 The November 2004 draft Investigation Manual describes a procedure by which cases which have been referred to the GMC by a public body may be referred into a local procedure. The GMC staff should contact the referring body to discuss the best way forward. This is entirely appropriate.

Informal Dialogue

25.122 During the Inquiry hearings, there was discussion about the need for the GMC, on receipt of a complaint (particularly one coming from a private individual), to contact the doctor's employer or primary care organisation (PCO) in order to ascertain whether there were any local concerns about the doctor. This had never been the GMC's practice in the past. As I explained in Chapter 18, some GMC members thought that such a practice would be unfair to doctors. However, Mr Scott told the Inquiry that the GMC intended to consider introducing such a practice.

25.123 After the Inquiry hearings, the GMC announced that, from May 2004, it would henceforth be operating a new policy for handling complaints at the initial stages of the FTP procedures. The intention was to discuss most complaints with the doctor's employers (which term I understand to include PCOs and others with whom the doctor is contracted to provide medical services). The purpose of these discussions would be, first, to discover whether the complaint was an isolated matter or an example of a wider concern about the doctor which had been recognised locally and, second, to inform those with local clinical governance responsibilities that the GMC was considering a complaint about the doctor. I understand that this change was put into effect under the old procedures and that it yielded useful information. The GMC has informed the Inquiry that, between May 2004 and September 2004, early disclosure to doctors' employers was made in 87% of cases. The remaining 13% were cases where the complaints made could not raise an issue for the GMC.

25.124 The position under the new procedures appears in the November 2004 draft Investigation Manual. In Stream 1 cases (those that will definitely require full investigation), the staff member will not enter into informal dialogue with the doctor's employer; in Stream 2 cases (those where it is not immediately clear whether or not a full investigation will be needed), dialogue will take place. The consent of the complainant to that disclosure will be required and the doctor will be informed. At a later stage, there will be formal disclosure of the allegation to the employer or PCO in both Stream 1 and Stream 2 cases, although this will be by letter and it is recognised that the employer or PCO might not respond.

25.125 Reports in the medical press have suggested that the new arrangements have been greeted with dismay by doctors. It has been said that the informal disclosure to employers and PCOs of the fact that a complaint has been made is 'unfair to doctors' since employers will be liable to draw adverse conclusions from the fact that a complaint has been made. At the time of writing, it had been reported that at least two medical defence organisations were challenging the right of the GMC to request a doctor's employment details for the

purpose of contacting his/her employers to discuss a complaint made against him/her at a stage earlier than the time for formal disclosure to employers.

25.126 I do hope that the GMC will not be deflected from making these enquiries. The obtaining of information from an employer or PCO is an essential part of the investigation. Moreover, I do not think that the fears voiced in the medical press have real foundation. I very much doubt that an employer or PCO will draw an adverse conclusion from the fact that an allegation has been made, unless it tends to confirm concerns that the employer or PCO already feels. If that is the position, it is right that the employer or PCO is made aware of the new allegation, in the interests of patient safety, and that the GMC is aware of the other pre-existing concerns. In Chapter 27, I recommend that this procedure should be enshrined in the Rules and that the GMC should have the power to require the doctor to provide any information necessary to permit these communications to take place.

Evidence Gathering

25.127 I shall now consider what, under the new procedures, the GMC proposes to do by way of evidence gathering. I have described in earlier Chapters how, under the old procedures, the GMC generally did little in the way of evidence gathering unless and until a decision had been taken to refer a case to the PCC for a hearing. As a consequence, a decision whether or not to refer a case to the PPC or the PCC would sometimes be taken on the basis of insufficient evidence and was in the past usually made without information about any previous concerns which might have arisen locally about the doctor's conduct or performance. I have already mentioned that, in its 2001 Consultation Paper, the GMC identified one of the weaknesses of the old FTP procedures as the limited investigation (in the sense of evidence gathering) carried out before a decision was made about what to do with a case. Mr Scott acknowledged this weakness in his evidence to the Inquiry when he observed that the old procedures put 'the cart before the horse' in that a decision was taken whether a case should be referred to the PCC before the necessary evidence had been gathered.

The 2003 Proposals

25.128 The 2003 draft Rules gave the Registrar the power, before referring a case to the IC or to a case examiner, to carry out such further investigations as in his opinion were appropriate. The Guidance that accompanied the 2003 draft Rules stated that these investigations might include writing to the doctor's employers and obtaining witness statements. Under the 2003 draft Rules, case examiners and the IC were also to have the power to carry out, or to direct the staff to carry out, further enquiries into cases, over and above the investigations already carried out by staff.

25.129 Despite the powers contained in the 2003 draft Rules, there was little in the other documents which the Inquiry had seen, before the GMC witnesses gave evidence in November and December 2003, to suggest that the GMC intended significantly to increase its evidence gathering activities at the investigation stage. Nevertheless, Mr Scott was adamant that, under the new FTP procedures, the approach would be quite different from that previously adopted. The GMC staff would, he said, undertake evidence

gathering. Mr Scott referred to the fact that the GMC was in the process of assembling a team of in-house lawyers, who would undertake evidence gathering. However, it was clear that the intention at the time he gave evidence was for the in-house lawyers to undertake investigations after a case had been referred to a FTP panel and not before; Mr Scott did not seek to say otherwise. He pointed out that some members of the existing office staff also had the potential to undertake investigative work. Mr Scott said that the case examiners would have a key role in directing what evidence gathering should be undertaken and in judging whether the evidence that had been collected was sufficient to enable them to reach a decision. The case examiners (unlike screeners in the old procedures) were to have powers to undertake and direct evidence gathering. Mr Scott emphasised to the Inquiry the 'profound nature' of this change which, he said, would ensure that **'the mindset'** of those operating the procedures would be 'fundamentally different' as a result.

The 2004 Position

25.130 Under the November 2004 Rules, the Registrar may, before deciding whether to refer a case to the case examiners, carry out such investigations as in his opinion are appropriate to the consideration of whether or not the allegation falls within section 35C(2) of the 1983 Act or of the doctor's fitness to practise. The Guidance that accompanies the November 2004 Rules suggests, by way of example, that the Registrar (personally or by his staff) may make enquiries of the doctor's employer in order to investigate whether the doctor's fitness to practise is impaired. The draft document 'Making decisions on cases at the end of the investigation stage: Guidance for Case Examiners and the Investigation Committee', produced by the GMC in September 2004 (the September 2004 draft CE/IC Guidance), states that initial investigations will be carried out by staff (with the assistance of lawyers where required), for example, in cases where there is insufficient evidence to establish whether the allegation falls within the GMC's jurisdiction or where further information is required to see if a pattern of behaviour may be established. It is said that such investigations may include making enquiries of the doctor's employer, colleagues or others, or obtaining medical reports or other documentation. I refer at paragraphs 25.153–25.154 to the arrangements for evidence gathering which are now envisaged.

25.131 After a decision has been taken to refer a case to the case examiners, the November 2004 Rules require the Registrar to carry out any investigations which, in his opinion, are appropriate to the consideration of the allegation by the case examiners. Such investigations may be carried out whether or not any investigations have been conducted prior to that stage. Surprisingly, in the light of what was said at the Inquiry's hearings about the key role which case examiners were to play in directing the process of evidence gathering and the fundamental change which would result, the May 2004 draft Rules omitted the power included in the 2003 draft Rules for case examiners to make enquiries into a case, or to direct the staff to make such enquiries. That power has not been restored by subsequent versions of the Rules. I do not know the reason for this omission.

25.132 The November 2004 draft Investigation Manual says that case examiners will be asked to approve an investigation plan and may wish to give instructions as to further forms of investigation to be carried out. It appears therefore that the investigations will be instigated

and carried out by the staff, but that case examiners should be able to give instructions, at least from the time when a case has been referred to them. That power is not reflected in the Rules. It should be; the case examiners should have the power to direct investigations.

Disclosure to the Doctor's Employer or Primary Care Organisation of the Fact that a Complaint Has Been Made

25.133 I shall now consider the point in the investigation stage process where the GMC is obliged to give formal notice to a doctor's employer or PCO that an allegation has been made about him/her.

Mandatory Disclosure: the 2003 Position

25.134 I have already explained in Chapter 18 that, after 2000, the GMC was required, in certain circumstances, to disclose the fact that it was investigating a complaint against a doctor to the Department of Health (DoH), and to any person or body by whom the doctor was employed or by whom s/he was contracted to provide services. Those circumstances arose once the GMC had made a decision to refer the doctor to the PPC, to invite him/her to agree to an assessment of his/her professional performance or to invite him/her to agree to undergo medical examination. In other words, disclosure took place after screening of a complaint and then only if the complaint was to go forward. Although referral of a case to the IOC was not included in the list of triggers for disclosure, the Inquiry was told that it was treated as such.

25.135 With the impending introduction of the new FTP procedures, the GMC had to consider at what point in the new procedures it would be appropriate for disclosure to take place. Under the 2003 draft Rules, disclosure would have been mandatory when the earliest of the following events occurred: referral of a case to an IOC for decision, referral of an allegation to a FTP panel, the making of a direction that a performance assessment should be carried out, the issuing of an invitation to a doctor to enter into voluntary undertakings or the issuing of a warning to a doctor. The inclusion of the last of these events as a trigger for disclosure suggests that it was contemplated at that time that the decision to issue a warning (rather than to refer a case to a FTP panel) might be taken before notifying (and, presumably, before obtaining background information from) the doctor's employer or PCO. That would seem to be another example of 'putting the cart before the horse', because the information available from an employer might have been such that a warning was insufficient to meet the seriousness of the case. It should be noted that, in a 'health case', the invitation to undergo a medical examination would not, under the 2003 draft Rules, have triggered disclosure; instead, the relevant trigger would have been the invitation to enter into voluntary undertakings under the equivalent of the old voluntary health procedures.

25.136 The effect of these new provisions would have been that, in many instances, disclosure would have taken place later under the new FTP procedures than had been the case since 2000 under the old procedures. It is not clear whether the GMC had intended this to be the consequence of the proposed changes or whether the effect was accidental. It would certainly have been an unfortunate retreat from the post-2000 position. It would have

meant that the GMC could have been in possession of relevant information for several weeks or months without disclosing that information to the relevant person or body.

25.137 As a result of evidence given to the Inquiry which indicated that the proposals would not command public confidence or support, of reservations expressed by the DoH and of an apparent recognition of its own obligation to provide timely information for the purposes of clinical governance, the GMC reconsidered its original proposals which, it was conceded, were **'clearly flawed'**. At a Council meeting held in November 2003, it was decided that disclosure should be brought forward to the point under the new procedures where the Registrar (in practice, a member of staff) or a case examiner took a decision that the complaint or other concern justified investigation.

Mandatory Disclosure: the 2004 Position

25.138 The May 2004 draft Rules therefore provided that a further event which would trigger disclosure should be a decision by the Registrar (in practice, a member of staff) to carry out or direct investigations before or after making the decision to refer a case to the case examiners. This would still have been unsatisfactory. This trigger would have been dependent entirely on whether or not any investigations were undertaken. If (as was invariably the case in the past) they were not, the doctor's employer or PCO would not be informed of the complaint at that stage. Even assuming that, in the future, the staff were to carry out investigations in most cases, there would almost certainly remain some cases in which there would be none. For example, when the fact that a doctor has been convicted of a criminal offence is reported, it will be open to the Registrar (or the staff, exercising his legal powers) to refer the conviction direct to a FTP panel. However, in some cases, he may not do so and will instead refer it to a case examiner. If, as he well might, he does so without carrying out any investigations, the duty to disclose would not have arisen, under the May 2004 draft Rules, until after the case examiner had made his/her decision.

25.139 Another change was that, under the May 2004 draft Rules, an invitation to undergo a health assessment was also to trigger disclosure. The issuing of an invitation to enter into voluntary undertakings remained in the list of triggering events although, since this would always be preceded by a health or performance assessment, it could never be the earliest event.

25.140 The July 2004 draft Rules contained further changes to the list of events that would trigger disclosure. These were reproduced in the November 2004 Rules. The issuing of a warning has been removed from the list. Instead, disclosure will have to take place at the earlier stage of referral of an allegation for consideration by the case examiners. This is a welcome change. It gives greater certainty and means that disclosure will, in general, take place earlier than would have been the case under the old procedures. Referral to case examiners is a step that will always happen in a case which is not closed by the staff at the initial stage, save when a conviction case is referred direct to a FTP panel, and such referral is also a triggering event. If pre-referral investigation takes place, this will bring forward the disclosure process. The issuing of an invitation to a doctor to enter into voluntary undertakings has been removed from the list of triggering events.

The Treatment of Convictions

25.141 I have described in earlier Chapters the treatment of conviction cases under the old FTP procedures. Convictions for minor motoring offences were not referred to the medical screeners and did not proceed beyond the office staff. In November 2002, the Registrar was given power to refer convictions for offences in respect of which an immediate sentence of imprisonment had been imposed directly to the PCC unless, in his opinion, such direct referral would not be in the public interest. All other conviction cases were referred to a medical screener and most of those cases were referred by the medical screeners to the PPC. In 2003, the PPC referred to the PCC less than a third of the doctors convicted of criminal offences whose cases had been referred to it. In Chapter 20, I mentioned the need, recognised by Mr Scott when he gave evidence to the Inquiry, for the GMC to make its treatment of conviction cases more consistent.

The 2003 Proposals

25.142 The 2003 draft Rules contained what amounted to a retreat from the post-November 2002 position. They provided that, in a case where a conviction had resulted in the imposition of a sentence of imprisonment, the Registrar **'may'** refer the allegation directly to a FTP panel. The Guidance which accompanied the 2003 draft Rules said that the Registrar was required to refer a conviction directly to a FTP panel where the doctor had received an immediate custodial sentence and where he **'considers it in the public interest to do so'**. This would have reversed the presumption which had existed since November 2002 that all convictions resulting in an immediate sentence of imprisonment would be referred to a FTP panel unless such a referral would not be in the public interest.

The 2004 Position

25.143 The May 2004 draft Rules (the provisions remain virtually unchanged in the November 2004 Rules) altered the position once again. The Registrar will now be required to refer directly to a FTP panel any conviction case which results in the imposition of a custodial sentence, whether immediate or suspended. This is a welcome change. It makes for greater certainty in that limited class of case. So far as any other conviction is concerned, the Registrar will be required to refer it direct to a FTP panel **'unless he is of the opinion that it ought to be referred to a medical and a lay Case Examiner for consideration'**. Although this latter provision creates a presumption in favour of referral, it gives a very wide discretion to the Registrar.

25.144 In September 2004, the GMC produced guidance (which was annexed to the September 2004 draft CE/IC Guidance) to members of staff and case examiners as to how they should deal with police cautions and with convictions which had not resulted in the imposition of a sentence of imprisonment. Members of staff are advised that they should refer direct to a FTP panel any case where the doctor has been convicted of a 'serious arrestable offence' within the meaning of the Police and Criminal Evidence Act 1984, of a racially motivated offence, of an offence involving child pornography, of an offence under the Misuse of Drugs Act 1971 (as amended) and of any offence involving an element of dishonesty. The guidance states that there is **'a presumption that the nature of these**

convictions means that the case will automatically reach the investigation stage test'.

25.145 At the other end of the scale, members of staff are advised that they may, unless the case has any exceptional aggravating factors, close cases which involve only a conviction for fixed penalty motoring offences, offences committed in the UK which are dealt with by substantially similar procedures, equivalent offences committed abroad and for offences whose **'main ingredient'** is the unlawful parking of a motor vehicle.

25.146 The guidance to staff states that all convictions (and, it seems also to be intended although it is not expressly stated, police cautions) not falling within any of the categories that I have previously described should be referred to case examiners. Case examiners should apply the investigation stage test in the same way as when dealing with non-conviction cases. They are advised that they must consider the seriousness of the case and that they are entitled to consider the doctor's fitness to practise **'in the round'**. Where there has been an assessment of the doctor's health (e.g. following a drink driving conviction), case examiners may authorise the staff to invite the doctor to agree voluntary undertakings. However, case examiners are reminded that, where there is a realistic prospect of erasure, the case must be referred to a FTP panel.

Comment

25.147 It appears to me that this guidance is clear and appropriate. I particularly welcome the guidance that all offences involving an element of dishonesty should be referred to a FTP panel. Case examiners may need guidance as to the kind of case in which there is a realistic prospect of erasure. Also, the guidance ought perhaps to make it plain that cautions are always to be dealt with in the same way as convictions. In my view, it should also be made plain that convictions resulting in a conditional discharge should be treated in the same way.

25.148 In my view, this guidance should be placed in the public domain. The question of whether a doctor convicted of a criminal offence should face a FTP panel is one in which members of the public have a legitimate interest. They should have the opportunity of contributing to a debate about which cases should be referred to a FTP panel and which should not. Moreover, the way in which the system operates in future should be transparent. The GMC should publish statistics showing a breakdown of the types of criminal offence and caution reported to the GMC and the outcomes of the decisions whether or not to refer such cases to a FTP panel and the reasons for the decisions taken. I suggest that the statistics should also show the final decisions taken by FTP panels in conviction and caution cases, so that it is possible to see clearly how the GMC deals with conviction and caution cases from beginning to end.

Closure of Cases by the Office Staff

25.149 When the Registrar decides not to refer an allegation to the case examiners, he (in practice, the staff exercising his powers) must notify the doctor, together with any person who brought the allegation to the attention of the GMC, of his decision and of the reasons for it.

Notification of the Doctor

25.150 The Guidance accompanying the November 2004 Rules states that the GMC will disclose to the doctor **'all complaints that are not wholly frivolous'**. Whether or not there has been prior disclosure of the allegation to the doctor, the November 2004 Rules require the Registrar, as soon as is reasonably practicable after referral of an allegation for consideration by the case examiners (or referral to a FTP panel in the case of a conviction which the Registrar refers direct to the adjudication stage), to write to the doctor, informing him/her of the allegation made against him/her and stating the matters which appear to raise a question as to whether his/her fitness to practise is impaired. The Guidance states that, if the Registrar intends to disclose the allegation to the doctor's employer or PCO before taking a decision whether to refer it to the case examiners, the doctor must be told of that intention. The doctor should also be sent copies of any documents received by the GMC in support of the allegation. The doctor will be invited to respond to the allegation by written representations within 28 days and will be informed that any representations received from him/her will be disclosed, where appropriate, to the maker of the allegation (if any) for comment. The July 2004 draft Rules provided (and the November 2004 Rules also provide) that disclosure of the doctor's representations to the maker of the allegation will be made only **'where appropriate'**. It is not clear in what circumstances it is envisaged that it would not be appropriate to make such disclosure.

25.151 There is no provision in the Rules requiring that the maker of an allegation should be shown the doctor's response and, if so, at what point in the proceedings. In evidence to the Inquiry, Mr Scott said that, in some cases, it would be evident from the first that an allegation should proceed. If the Rules required that the maker of the allegation should be invited to provide comments before referral of the case to a case examiner or to a FTP panel, this might cause delay. He said that it was better to leave the decision whether to invite comments from the maker of the allegation in the hands of the Registrar or case examiners. I can see that that would be sensible where it was clear that the case was to proceed, whatever the response of the maker of the allegation were to be. However, if there were any doubt about whether the case should proceed, it seems to me to be necessary to obtain the comments of the maker of the allegation before a decision is made. When giving evidence, Mr Scott gave an undertaking that comments would be invited from the maker of the allegation in any case where there might be doubt about whether to send the case to a FTP panel. I note that the November 2004 draft Investigation Manual instructs caseworkers to disclose to the maker of the allegation the doctor's comments on those parts of the allegations that have come from him/her. This appears to give effect to Mr Scott's undertaking to the Inquiry. However, as I have said, the requirement to make disclosure to the maker of the allegation has not been incorporated into the Rules. I think it would be preferable for this to be done. Mr Scott said that it would be too difficult to include this provision in the Rules without tying the GMC to seeking the complainant's comments in every case; that, he said, would cause unnecessary delay. However, I think that, with a little ingenuity, it could be managed.

Further Evidence Gathering

25.152 I have already said that, under the November 2004 Rules, after a decision has been taken to refer a case to a case examiner, the Registrar will be required to carry out such investigations as in his/her opinion are appropriate to the consideration of the allegation by the case examiners. In particular, the Registrar (or the staff, exercising his powers) will at this point be able to direct that an assessment of a doctor's performance or health should be carried out. This provision first appeared in the May 2004 draft Rules. Previously, and at the time of the Inquiry hearings, it had been intended that the power to direct a health assessment should be exercised only by a medically qualified case examiner or the IC. It had been suggested that the IC might not wish to delegate (at least in the short term) even to a medically qualified case examiner the decision whether to direct a performance assessment. I shall discuss this new power conferred on the Registrar when I deal with the arrangements for dealing with cases involving issues of health and performance.

25.153 The September 2004 draft CE/IC Guidance states that cases will be allocated to 'investigation teams' (each comprising a lawyer, an investigation manager, a number of investigation officers and case examiners). The draft Guidance says that regular team meetings will be held, at which decisions will be taken about the investigations required and progress will be reviewed. Lawyers (both in-house and external) will carry out certain investigations and will advise on those required. In a letter to the Inquiry, the GMC has said that the investigation of cases will be **'a lawyer-led process'**. The September 2004 draft CE/IC Guidance says that such investigations may include obtaining witness statements and expert reports, as well as directing health or performance assessments.

Comment

25.154 The GMC says that it intends to employ staff, both legal and non-legal, to carry out evidence gathering at the investigation stage. Since the Inquiry's hearings, I have seen advertisements in the newspapers seeking staff to carry out investigative work. This is a most welcome development. I do hope that a culture will be established within the GMC of proactive investigation, carried out with real determination and inquisitiveness – rather than by following a set protocol, at the end of which the investigation is regarded as complete, regardless of whether the issues have been 'bottomed'. I would hope also that an early opportunity will be taken to restore to the case examiners the power, which was proposed under the 2003 draft Rules, to direct that any investigations which they deem necessary should be carried out.

Consideration of Cases by Case Examiners

25.155 I shall now turn to examine the process by which the case examiners will consider cases and make decisions upon them.

25.156 During 2003 and 2004, the GMC was engaged in devising guidance for the use of case examiners and (latterly) of IC panels. The Inquiry has seen three drafts of such guidance.

These are the 2003 draft Case Examiner Guidance and the September 2004 draft CE/IC Guidance, to which I have already referred, together with the draft document, 'The Investigation Stage Test – Guidance on Criteria and Thresholds', produced by the GMC in June 2004 (the June 2004 draft Case Examiner Guidance).

25.157 The Inquiry has also seen drafts, produced in 2003 and in June and September 2004, of the case examiner decision forms (CEDFs) to be used by case examiners when recording their decisions.

25.158 The GMC told the Inquiry that it intended to pilot the Guidance and CEDFs during a trial period in October 2004, after which they will be amended further as necessary.

The Test to Be Applied

25.159 The test to be applied at the end of the investigation stage will, as I have said, be whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. The impairment might arise by reason of misconduct, deficient professional performance or adverse health, or as a result of a conviction or caution or as a result of a determination by another professional regulatory body. I have already discussed the problems that arise in connection with this test and my ideas as to how these problems might be rectified and I shall not repeat my observations here.

Guidance on the Approach to Be Applied

25.160 The November 2004 Rules contain no criteria to be used by case examiners when applying the investigation stage test. However, some insight into the approach that case examiners are expected to adopt can be gleaned from the 2003 draft Case Examiner Guidance, the June 2004 draft Case Examiner Guidance and the September 2004 draft CE/IC Guidance.

Cases Which Give Rise to a Presumption of Impaired Fitness to Practise

25.161 Case examiners will first of all have to evaluate whether an allegation is serious enough to indicate that the doctor's fitness to practise may be impaired to a degree justifying action on the doctor's registration. The September 2004 draft CE/IC Guidance advises that certain categories of conduct, namely sexual assault or indecency, violence, improper sexual/emotional relationships and dishonesty, should be referred by case examiners to a FTP panel unless there are **'exceptional reasons'** for not doing so. These categories of conduct are the categories which had previously constituted 'SPM by definition', save that 'dysfunctional conduct' has now been replaced by the narrower category of 'improper sexual/emotional relationships'. In such cases, there will be a presumption of impaired fitness to practise and, therefore, no need to consider the issue of seriousness.

25.162 The September 2004 draft CE/IC Guidance advises that, where case examiners consider that there is no realistic prospect of establishing a case evidentially, they should not **'normally'** close the case without first obtaining legal advice. Case examiners are advised

to record on the CEDF the reasons for their decision, referring specifically to any legal advice received.

25.163 The June 2004 draft Case Examiner Guidance had advised case examiners that they should not **'normally'** consider any arguments in mitigation raised by the doctor when considering whether to refer a case involving these categories of conduct to a FTP panel. However, that advice was omitted from the September 2004 draft CE/IC Guidance. I am concerned about that omission because I think the advice is important. It is clear from cases examined under the old procedures that the screeners often used to take mitigating factors into account quite inappropriately.

Considerations of Seriousness

25.164 The September 2004 draft CE/IC Guidance then sets out the approach to be adopted in other cases (usually involving complaints about a doctor's clinical practice), where there may be serious or persistent failures to meet the standards in 'Good Medical Practice' which raise an issue of impaired fitness to practise. It advises that not all failures to meet standards will involve an impairment of fitness to practise of a degree sufficient to justify action on the doctor's registration. When considering whether the impairment is of such a degree, case examiners are advised that they should consider both the nature and the seriousness of the allegations. They will need to consider also the persistent and serious nature of any failures to meet the standards in 'Good Medical Practice'. The September 2004 draft CE/IC Guidance then sets out a number of circumstances in which a question of fitness to practise is likely to arise. These are:

- **'A doctor's performance has harmed patients or put patients at risk of harm'**
- **'A doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients'**
- **'A doctor has abused a patient's trust or violated a patient's autonomy or other fundamental rights'**
- **'A doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others'**
- **'The doctor's behaviour was such that public confidence in doctors generally might be undermined if the GMC did not take action'**
- **'A doctor's health is compromising patient safety.'**

25.165 This list of circumstances is helpful. However, it seems to me that case examiners need some specific examples by which to gauge whether the threshold is crossed in the particular case under consideration. What is required is a comprehensive set of case examples showing where the threshold should lie.

25.166 If the case examiners consider (taking into account all the above) that the allegation is of sufficient seriousness to have the potential to justify action on registration, they must then consider whether there is a realistic prospect of establishing the case evidentially.

Consideration of the Evidence

25.167 The September 2004 draft CE/IC Guidance sets out advice on how case examiners should approach the question of whether there is a 'realistic prospect' of establishing, in an individual case, that a doctor's fitness to practise is impaired to the required degree. The advice is in terms almost identical to those in the *aide memoire* which was first produced in January 2001 for the guidance of the PPC (although the *aide memoire* spoke of a **'real'**, rather than a **'realistic'** prospect). The September 2004 draft CE/IC Guidance includes a reminder that the criminal standard of proof applies in cases heard by a FTP panel.

25.168 The advice contained in the September 2004 draft CE/IC Guidance that case examiners should not **'normally'** close a case for evidential reasons without obtaining legal advice appears to extend only to cases which carry a presumption of impaired fitness to practise. It seems that, in all other cases (most of which will be cases involving allegations about clinical practice), case examiners will be free to form their own views about evidential issues, guided by the modified *aide memoire*.

Comment

25.169 Assessing the weight of evidence is essentially a legal process and can be quite difficult for non-lawyers. It may be that, in cases involving evidential issues, case examiners will seek the advice of the lawyers in their investigation teams. However, I find it worrying that they are not specifically advised to do so. It seems to me also that the modified *aide memo*ire may be unhelpful in some respects. The reminder that the standard of proof is the criminal standard is likely to create the impression that, if the evidence is disputed by the doctor, the allegation will not be capable of proof, whereas, in fact, if the FTP panel believes the account given by the maker of the allegation, it might find the allegation proved.

25.170 The September 2004 draft CE/IC Guidance also offers advice about the circumstances in which case examiners should consider whether a warning might be appropriate. I shall refer to that advice later in this Chapter.

The Possible Outcomes of the Consideration of a Case by the Case Examiners

25.171 The November 2004 Rules provide that medical and lay case examiners will have a number of options when deciding how to dispose of a case which is referred to them. First, they may direct that the case should not proceed further. It seems that, if the case examiners direct that a case should not proceed further, it will be open to them also to direct that a letter of advice should be sent to the doctor. This option is not mentioned in the Rules or in the September 2004 draft CE/IC Guidance. I shall consider this issue further below.

25.172 Second, the case examiners may decide to issue a warning to the doctor or to refer the allegation to the IC for an oral hearing, with a view to a warning being issued. I shall discuss that option further below. Third, the case examiners may refer the allegation for determination by a FTP panel. I shall deal with the procedure following such a referral later in this Chapter. Finally, the case examiners may recommend that the doctor should be

invited to comply with undertakings following an assessment of his/her performance or health directed by a member of the GMC staff. If such an invitation is issued and if the doctor confirms that s/he is prepared to comply with such undertakings, the case examiners will cease consideration of the case and the case will then be dealt with by way of voluntary undertakings. I shall deal with this option later in this Chapter.

25.173 Both case examiners must agree on how the case should be dealt with. In the absence of agreement, the case will automatically be referred to the IC.

Letters of Advice

25.174 I have explained in Chapter 19 how, under the old FTP procedures, it was open to a medical screener, having taken a decision not to refer a case to the PPC, to send a letter of advice to a doctor under Chapter XV of GMC Standing Orders. The PPC also sent warning letters and letters of advice in some cases which it had decided not to refer to the PCC for a hearing.

The 2003 Proposals

25.175 The 2003 draft Rules contained no specific provision for the sending of a letter of advice in a case which a case examiner had decided should not proceed further. Nevertheless, the Guidance which accompanied the 2003 draft Rules stated:

> **'Where a case is concluded with no further action, the Committee** (*the IC*) **or Case Examiner may issue advice about the practitioner's future practice or behaviour in such terms as they see fit.'**

25.176 The 2003 draft CEDF contained a section in which a case examiner was to record his/her decision whether or not to issue a letter of advice, together with reasons for the decision. The 2003 draft CEDF suggested that a letter of advice would probably be appropriate where a case examiner was **'satisfied that the case does not meet the investigation stage test and does not warrant a warning'**. Three examples were suggested of circumstances in which it might be appropriate to send a letter of advice. The first example was where there had been a **'minor breach in professional standards'**, such as unreasonable delay in sending a promised medical report. The second example was where the doctor had been convicted of a **'minor criminal offence (such as breach of the peace)'**. The third example was where the **'issues'** had **'been resolved locally to the satisfaction of the parties'** and **'confirmation of any advice given locally would be useful'**. The FPPC's paper which was considered by the Council at its meeting in November 2002 had suggested that the terms of any letter of advice sent to a doctor should be disclosed only to the doctor and to the complainant. The letter would not be disclosed to the doctor's employer or PCO. Nor would it be disclosed to anyone who subsequently enquired about the doctor's registration status. It was, however, intended that a letter of advice (together with any complaints against the doctor received locally) would be considered as part of the appraisal process.

The 2004 Position

25.177 The May and July 2004 draft Rules also contained no provision for the sending of letters of advice. Nor do the November 2004 Rules. The June 2004 draft Case Examiner Guidance and the September 2004 draft CE/IC Guidance make no mention of letters of advice. All references to letters of advice have also been removed from the June and September 2004 drafts of the CEDF. The June 2004 draft CEDF did request a case examiner, if s/he had decided that a case should not proceed further, to note the main points to be covered in the letter to be sent to the doctor. It seemed possible that case examiners would be instructed by the GMC that they might include in those points some form of advice to the doctor as to his/her future conduct. That section has been omitted from the September 2004 draft CEDF, which is much shorter than previous versions.

25.178 In a letter to the Inquiry, the GMC has stated:

> **'... it will of course remain open to the GMC to provide advice to a doctor in any terms that it considers appropriate when no formal action (including a warning) is required, but to do so is considered desirable in the interests of maintaining good professional standards. It is anticipated that this power will be used only very sparingly and the GMC is considering how best to reflect this in its internal guidance to staff including Case Examiners.'**

25.179 It appears, therefore, that, despite the fact that all reference to letters of advice has been removed from the draft CEDFs and Guidance, it is contemplated that, on occasion, cases will be dealt with by sending a letter of advice. Whether this power will be used sparingly in future remains to be seen. Under the old procedures, many such letters were sent.

Comment

25.180 There is nothing intrinsically wrong with the sending of a letter of advice; indeed, it may be a good idea, provided that it is not allowed to become a 'soft option' and an alternative to referring a case which, in reality, satisfies the investigation stage test and should therefore be referred to a FTP panel. But, if it is thought to be of value to retain letters of advice, the option should be written into the Rules and proper criteria should be agreed and established for the sending of such letters. Their use should be audited, so as to ensure that they are being used appropriately. It is not acceptable to start the new procedures with part of the process going on outside the Rules. If letters of advice are to be retained, they may – indeed should – be of relevance to the process of revalidation. It would be unfair to doctors if there were inconsistency of treatment in the sending of letters of advice. In the 2001 Consultation Paper, the GMC singled out the lack of transparency in relation to letters of advice as one of the weaknesses of the old system. The present uncertainty has done nothing to remove the obscurity of the old arrangements.

Warnings

25.181 A novel feature of the new FTP procedures is the mechanism for issuing formal warnings to doctors at the investigation stage. Section 35C(6) of the 1983 Act provides that, if the

IC decides that a case ought not to be considered by a FTP panel, it may issue a warning to the practitioner about his/her future conduct or performance. Because there is no express statutory test to be applied to the question of whether a case **'ought not'** to be considered by a FTP panel, the circumstances in which a warning may lawfully be given are not clear from the statute.

The Circumstances in Which a Warning May Be Issued

25.182 The GMC's intention is that a warning will be available where an allegation does not, in the view of the case examiners or the IC, warrant referral to a FTP panel, but where there is evidence to suggest that the doctor's behaviour or performance has fallen below acceptable standards to a degree warranting formal censure by the GMC. The September 2004 draft CE/IC Guidance states:

> **'There will also be cases that demonstrate significant departures from *Good Medical Practice* not so serious as to warrant action on a doctor's registration but requiring a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response in these types of cases will be a warning.'**

25.183 A warning will **'remain valid'** for a period of five years. No decision has yet been made by the GMC about whether a warning should ever be regarded as 'spent' (and, therefore, not discloseable) after five years. The fact that a warning has been issued will be disclosed to the doctor's current employer or PCO and to the person or body who brought the allegation to the attention of the GMC. In addition, it will be disclosed to any prospective employer. It will also be disclosed to any enquirer during the period of the warning's validity. As I understand the position, an 'enquirer' would have to make a specific enquiry about whether a doctor had a FTP history (not just whether s/he was registered or whether there were restrictions on his/her registration) before the fact of the warning would be revealed. At a meeting of the Council in July 2004, Mr Scott told members how office staff provide such information. They answer only each question specifically asked and do not volunteer any additional information.

The 2003 Guidance

25.184 The 2003 draft Case Examiner Guidance advised case examiners to consider four questions when deciding whether a warning was appropriate. These were:

> **'a. Was the doctor's conduct incompatible with his standing as a doctor?'** The 2003 draft Case Examiner Guidance suggested that a warning might be appropriate following conviction for certain categories of criminal offence (e.g. an isolated incident of shoplifting), where the offence had not taken place in a professional context.
>
> **'b. Has the doctor failed to address concerns raised by local management?'** It was suggested that a warning might be **'a means of**

underlying (*sic*) **the seriousness of the concerns and stressing that any misconduct must not be repeated'**.

'c. Is there a need to flag up our concerns with the doctor's employer(s)?' The 2003 draft Case Examiner Guidance suggested that the fact that a warning would be disclosed to the doctor's employer(s) would have the effect of **'ensuring that employers are aware that aspects of the doctor's practice may need to be monitored'**.

'd. Are there any identifiable areas of a doctor's practice in need of assessment or retraining?'

25.185 The 2003 draft Case Examiner Guidance went on to state:

> **'A departure from Good Medical Practice may be viewed as sufficiently significant to justify a warning where it is serious enough for us to mark the fact that the doctor's behaviour was unacceptable and must not happen again, but that it would be disproportionate to take action against the doctor's registration.'**

25.186 At the Inquiry's hearings, it was suggested to witnesses from the GMC (in particular, Sir Graeme Catto and Mr Scott) by Leading Counsel to the Inquiry that the new power to issue formal warnings might make it tempting for case examiners or the IC, in a case where they were uncertain whether a FTP panel would find the facts proved, to opt for the 'bird in the hand' and to issue a warning in a case that ought really to be referred to a FTP panel. This possibility did not appear to have occurred to any of the witnesses previously, although it did appear to the Inquiry to be an obvious danger.

The 2004 Guidance

25.187 The September 2004 draft CE/IC Guidance makes clear that a warning should be considered only where the case examiners have already decided that the investigation stage test has not been met. Moreover, case examiners are advised that, where they consider that allegations are **'borderline between action on registration and a warning'**, the presumption should be that the allegations should be referred to a FTP panel. It seems to me that this draft Guidance, if adhered to, satisfactorily deals with the Inquiry's concern.

25.188 The June 2004 draft Case Examiner Guidance advised also that, where case examiners had decided that the allegations met the investigation stage test, they should not permit any mitigating factors to persuade them to issue a warning, instead of referring the case to a FTP panel. Rather, it should be left to the FTP panel to consider any mitigating factors and the appropriate circumstances. I considered that to be a welcome change in the advice because, as I mentioned earlier, the Inquiry's examination of cases under the old procedures showed that screeners and the PPC often took mitigation into account when they should not have done. However, the advice has been omitted from the September 2004 draft CE/IC Guidance. Indeed, the only reference to mitigation occurs when case examiners are advised that, once it has been established that the investigation stage test has not been met, they should consider all the evidence (including mitigation) when

deciding whether or not to issue a warning. In my view, the advice on mitigation given in the June 2004 Guidance should be reinstated. The GMC must be alert to the potential problem that the case examiners may take mitigating factors into account inappropriately. They should monitor case examiners' decisions to ensure that they are not mistakenly taking mitigating factors into account and issuing warnings in cases that should have gone to a FTP panel. This is important in the interests of protecting patients.

25.189 The September 2004 draft CE/IC Guidance makes no reference to the four questions which the 2003 draft Guidance had suggested the case examiners should consider when deciding whether a warning was appropriate. Nor does it give any further guidance on how a decision whether or not to issue a warning should be approached. The June 2004 draft Case Examiner Guidance had included a few examples of the types of case which might attract a warning. These were brief and contained no detail. They have been omitted from the September 2004 draft CE/IC Guidance. In my view, they should be reinstated because the provision of examples is always helpful. However, what is really needed is not these brief examples but more detailed case studies, covering a much wider range of topics and demonstrating, by the use of more than one case of a similar nature, where the dividing line has been – properly – drawn and why.

Procedure: Notice to the Doctor: the 2003 Proposals

25.190 The 2003 draft Rules set out an elaborate procedure for the issuing of warnings. Where the IC or a case examiner considered that a warning might be appropriate, the doctor would be given notice that a warning was being considered and would be informed of his/her right to make representations in writing. Although the 2003 draft Rules were silent on the point, it appeared that, if no representations were received, or if the doctor indicated that s/he was prepared to accept the warning, a written warning would be issued. If the doctor contended that a warning should not be issued, his/her representations would be considered by an IC panel or a case examiner, and a decision would then be taken as to whether an oral hearing, to determine whether the warning should be issued, was desirable. The question of whether there should be an oral hearing was a matter for a case examiner or the IC panel; there was no right to such a hearing.

Procedures: Notice to the Doctor: the 2004 Position

25.191 Under the May 2004 draft Rules, the provisions for the issuing of warnings were simplified. There was to be no opportunity for the doctor to make written representations specifically on the question of whether a warning should be issued. Presumably, it was intended that the case examiners would take into account, when making their decision, any written representations which had been submitted by the doctor when s/he had first been invited to comment on the allegation made against him/her. Doctors still had no right to insist on an oral hearing.

25.192 The July 2004 draft Rules (which are reproduced in this respect by the November 2004 Rules) reinstated the opportunity for a doctor to make written representations once the case examiners have indicated that they are considering issuing a warning. The case examiners must consider those written representations when deciding how to deal with

the case. The July 2004 draft Rules conferred for the first time a right on a doctor to an oral hearing if s/he chose. This change was intended to meet the concerns of doctors about the new warning procedures. The right to a hearing has been retained in the November 2004 Rules.

The Case Examiners' Decision

25.193 Once the doctor's written representations have been received (or if s/he does not respond to the invitation to provide representations), the case examiners have three options for dealing with the case. The first option is to issue a warning to the doctor. The November 2004 Rules provide that, if the case examiners are satisfied that the allegation **'ought not to be considered by a FTP Panel'** and if the doctor does not make any representations, or if it appears from his/her representations that s/he has not contested the facts upon which the allegation is based, the case examiners may, if they think fit, issue a warning to the doctor.

25.194 The second option is to refer the doctor for an oral hearing before the IC. Case examiners must exercise this option if the doctor requests an oral hearing before the IC, or if they consider it appropriate for some other reason to refer the case for an oral hearing. The third option (which is not explicitly set out in the relevant rule but must, I think, be open to case examiners) is to direct that the case should not proceed further. A direction that a case should not proceed further may be made if it is clear that the doctor is disputing the facts and if the case examiners do not consider, having taken into account the doctor's representations, that it is appropriate to refer the case to the IC for an oral hearing.

25.195 It should be noted that there is no provision for the maker of the allegation to be notified of the fact that a warning is being considered. Nor is there any provision for the maker of the allegation to be shown, or asked to comment on, the doctor's written representations as to whether a warning should be issued.

Comment

25.196 The process by which a warning may be issued following the decision by a case examiner that that would be an appropriate course is potentially complex, time-consuming and expensive. It may result in a hearing before an IC panel which is virtually as resource-intensive as a full hearing before a FTP panel. It may even result in a FTP panel hearing, if new evidence emerges at the IC panel hearing. I shall make some comments and suggestions about this procedure when I have completed my description of all the processes by which a warning may be given during the investigation stage.

Cases Dealt with by the Investigation Committee

25.197 I have explained that, under the November 2004 Rules, IC panels will deal with only two categories of case. The first category consists of cases where the two case examiners have been unable to agree. The second consists of oral hearings for the purpose of deciding whether a warning should be issued.

25.198 The GMC will maintain a list of medical and lay associates, who will be eligible to act as IC panellists. As I have already explained at paragraph 25.90, although, under the Constitution Rules 2004, GMC members will be eligible to sit on IC panels, it is not yet certain whether they will in fact do so. There is a division of opinion among Council members about whether this is appropriate. Whatever the long-term outcome of that debate, IC panels will be chaired by panellists who have undergone assessment and have been appointed for the purpose. Chairmen of panels may be medical or lay. The legal quorum of an IC panel will be three, including a medical and a lay panellist.

25.199 Decisions of IC panels are to be reached by a simple majority. If the votes are equal, the decision will go in favour of the doctor. IC panels will sit with a legal assessor when considering warnings.

Cases Where the Case Examiners Have Disagreed

25.200 In cases where the case examiners have been unable to agree, an IC panel will decide the case in private and on paper. Neither the maker of the allegation nor the doctor will have the right to attend or to be represented. The panel may adopt one of five courses of action.

25.201 First, the panel may determine that the allegation should not proceed further. It seems that, if it makes such a determination, it will have the option of sending a letter of advice to the doctor in the same way as the PPC frequently did under the old procedures. I have already expressed concern that there is no mention in the Rules about letters of advice. If they are to be sent, the circumstances in which this will happen should be set out in the Rules and there should be clear criteria for the circumstances in which this will be done.

25.202 The second option open to the IC panel will be to issue a warning to the doctor without an oral hearing. Where a warning is being considered, the doctor will be given the same opportunity to provide written representations about the issue as if the case examiners had initiated the warning process. The IC panel will then have the option, where the doctor has made no representations or has not contested the facts, of issuing a written warning without a hearing. The third option that the IC panel will have is to decide that an oral hearing should be held in front of a differently constituted panel of the IC. That panel would then decide whether a warning should be issued. Fourth, the IC panel may refer the allegation for determination by a FTP panel. The fifth option arises where the case examiners have failed to agree whether to recommend that a doctor should be invited to comply with undertakings following a performance or health assessment. In that event, the IC panel may determine that the doctor should be invited to comply with such undertakings as the panel thinks fit.

25.203 The November 2004 Rules give the IC no power to direct that any investigations should be carried out, or to adjourn for investigations to be carried out, when dealing with a case where the case examiners have disagreed. Under the old procedures, the PPC had the power to adjourn for further investigations. Furthermore, an IC panel has no power to direct a health or performance assessment in such cases. In my view, the IC should have these powers and I shall recommend that they be provided.

Oral Hearings for the Purpose of Deciding Whether to Issue a Warning

25.204 The 2003 draft Rules provided that an oral hearing held by an IC panel for the purpose of deciding whether to issue a formal warning was to be conducted in private. As for the procedure to be adopted at such a hearing, the 2003 draft Rules would have permitted the Presenting Officer (i.e. the person presenting the case for the GMC, usually a solicitor or counsel) to outline the allegations against the doctor, but not to adduce any evidence. By contrast, the doctor or his/her representative was to have the right to adduce oral or documentary evidence and to address the panel on the appropriate outcome. The 2003 draft Rules provided no opportunity for the Presenting Officer to make further submissions about the evidence adduced by the doctor or about any representations that had been made on the doctor's behalf. The draft 2003 Rules specifically stated that the maker of an allegation had no right to appear before the IC panel and, indeed, the relevant person or body would almost certainly have been unaware that the oral hearing was being held or, indeed, that the possibility of issuing a warning was being contemplated. The IC panel was to be required to give only **'brief reasons'** for its decision, which would have been communicated subsequently to the maker of the allegation.

25.205 At the time of the Inquiry's hearings, I had some concern about the proposal to hold these oral hearings in private. A significant – and very welcome – change introduced by the May 2004 draft Rules (and reproduced in the November 2004 Rules) is that oral hearings in relation to warnings are now to be held in public. I was also concerned at the proposed procedure at such hearings, which was to be wholly one-sided, with only the doctor being permitted to adduce evidence. This arrangement was changed by the May 2004 draft Rules, which would have permitted the Presenting Officer to adduce any relevant oral or documentary evidence and to make further submissions after the doctor had given his/her evidence. This would have disposed of most of the concerns I had about the one-sided nature of the process. If there had been provision for the maker of the allegation to attend the hearing, to give evidence if appropriate and otherwise to provide information to the Presenting Officer, my concerns on that score would have been completely allayed.

25.206 The July 2004 draft Rules (reproduced in the November 2004 Rules) introduced yet further changes. Now, the Rules provide that, once the Presenting Officer has outlined the allegation and the facts upon which it is based, the doctor may respond to the allegation. Both the Presenting Officer and the doctor may adduce any relevant oral or documentary evidence only **'where the Committee considers such evidence is desirable to enable it to discharge its functions'**. The Presenting Officer may then make such further submissions as the IC panel shall allow.

25.207 The effect of these changes is that it is now wholly within the discretion of an IC panel to decide whether or not oral evidence is called or documentary evidence is admitted. The nature and extent of the evidence to be admitted or called is also within the panel's discretion. The Guidance which accompanies the November 2004 Rules states that:

> **'... there is a presumption that evidence will not be received, and this is at the discretion of the Committee** (*i.e. the IC panel*) **considering the case. As the Committee has no power to impose a sanction which will affect the practitioner's registration, it will generally be the case that the**

practitioner's rights, and the public interest, will adequately be served by a summary hearing of this kind.'

25.208 The maker of the allegation will have no right to be notified of the hearing although it is possible that s/he will be called by the GMC to give evidence, if the IC panel permits this.

25.209 In contrast with the position where the IC panel is seized of a case because the case examiners have disagreed, the IC panel may, before reaching its decision, adjourn for further investigations to be carried out, including an assessment of a doctor's health or performance.

25.210 At the conclusion of the oral hearing, the panel can issue a warning or determine that the case should not proceed further. A third option, which arises where new information adduced into evidence at the hearing indicates that to do so would be appropriate, is to refer the allegation for determination by a FTP panel. However, it seems likely that that would be a rare occurrence if it is not intended that evidence should usually be called.

25.211 The Guidance accompanying the November 2004 Rules states that any disputes of fact at an oral hearing relating to a warning will be decided on the basis of the civil standard of proof. Once it has reached its decision, the IC panel must announce the decision and give its reasons (the November 2004 Rules require **'reasons'**, rather than **'brief reasons'**) for that decision.

25.212 At the moment, it is impossible to know how these procedures will work in practice. If disputes of fact are to be resolved, the IC panel will have to receive oral and documentary evidence. It is to be hoped that panels will not make findings of fact on the basis of representations alone. If evidence is to be heard, it must be heard from both sides. The presumption that evidence will not be received gives rise to practical problems. If it is not expected that evidence will be heard, witnesses will not be warned to attend the hearing. Of course, the doctor is likely to be there, but it would be quite wrong for the IC panel to allow the doctor to give evidence when the GMC had not even arranged for its witnesses to attend. On the other hand, it would obviously be unsatisfactory if witnesses were to be required to attend, only to find that the IC panel would not permit them to give evidence. It may be that there will have to be a preliminary hearing before the same IC panel to determine what the issues are and whether oral and documentary evidence will be received. It seems to me that, even if oral evidence is not to be heard, the maker of the allegation ought to be entitled to attend. Without the presence of that person, the Presenting Officer may have no one from whom to obtain information in relation to the representations made on the doctor's behalf and the procedure will inevitably be one-sided. Such a process would not, in my view, provide adequate protection for patients and the public interest.

Comment

25.213 These proposed arrangements for the giving of warnings create a potentially complex, time-consuming and expensive procedure. Although it is said that the oral hearing will be more **'summary'** than that which takes place before a FTP panel, that will not necessarily be so. If evidence is to be admitted, there will be very little difference. It is said that this

more **'summary'** procedure is appropriate and not unfair because the sanction that might be applied does not affect the doctor's registration. That is true, but a warning is a serious matter, will be disclosed to enquirers and in effect goes into the public domain. The GMC says that warnings will 'feed into' the revalidation process, although it is not clear to me at what stage that will happen or what effect a warning would have on whether or not a doctor was revalidated. I note, as a matter of interest, that the 2003 draft Case Examiner Guidance and the June 2004 draft Case Examiner Guidance advised case examiners that a warning should be regarded as a **'serious sanction'** or a **'serious matter'**. The more recent Guidance omits that advice. Nonetheless, it seems to me that the issue of a warning that is disclosed to anyone who enquires is a serious matter and the fact that the GMC wishes to give doctors the right to an oral hearing shows that it recognises that. The giving of a warning is also an important matter from the public point of view. The GMC has recognised that, by deciding that oral hearings in connection with warnings should take place in public.

25.214 I mentioned in paragraphs 25.56–25.58 above that, in my view, the GMC's investigation stage test has been set at the wrong level. Errors of principle such as this usually give rise to practical problems. In my view, the GMC's present difficulties with the issue of warnings within the investigation stage illustrate that problem. If the GMC were to adopt the investigation stage test that I have proposed at paragraph 25.63, all cases that might warrant a warning would automatically go through to a FTP panel. The case examiners and IC would be applying their minds to objective criteria and not trying to guess what sanction might be imposed. If the case did not pass the investigation stage test, the case would be closed, with or without a letter of advice. There would be no warnings at the investigation stage and no need to devise a special **'summary'** procedure with discretion to admit evidence and all the practical problems that will create.

25.215 It seems to me that the practical problems of the proposed oral hearings are very significant. If the discretionary question of whether evidence is to be received is to be decided by the IC panel in every individual case, there will have to be a preliminary hearing in every case. This will have to take place before the same IC panel as will sit on the substantive hearing; a discretionary decision on the admissibility of evidence cannot be taken by a case manager. The expense will be considerable. The only other option is to have a full hearing in every case. I quite understand the disadvantages in that, especially since there is (theoretically at least) the possibility that, at the end of such a hearing, the case might be referred by the IC panel to a FTP panel, which might involve a rehearing of the same evidence.

25.216 If the GMC decides to maintain its present position, a number of problems arise, apart from the ones I have already mentioned. I fear that the complexity of the procedure will result in a lot of borderline cases foundering with no action being taken. Case examiners may be tempted not to send cases for an oral hearing if there is a significant dispute of fact, particularly if it is known that the IC has a lot of work.

25.217 If the present provisions are to be implemented, it is essential that their operation be properly audited. It will be necessary to collect statistics to show how many cases are closed after the invitation for written representations on the giving of a warning has been

issued, i.e. without any action being taken. The GMC should analyse which types of case are being dealt with by way of warning and whether this is appropriate. Under the old procedures, letters of advice and warnings were often issued in cases which should have proceeded to a hearing.

25.218 I do hope that the GMC will consider these observations about the giving of warnings within the investigation stage, together with my concerns about the investigation stage test. The two are closely related and both problems could be resolved in the way I have suggested.

Cases Where the Doctor's Fitness to Practise Is or Might Be Impaired by Adverse Health

25.219 At present, it is envisaged that arrangements which are in many respects similar to the old voluntary health procedures will continue under the new procedures. However, Mr Scott told the Inquiry that the treatment of some health cases would be very different. He said that cases where the issues were only about impairment of health might be dealt with separately under a procedure akin to the old voluntary health procedures. However, health cases with 'complicating factors' would not. If, for example, a doctor had convictions for drug offences, then, despite the fact that the case involved health issues, it would have to go to a FTP panel. It would then be open to the FTP panel to direct that the doctor be referred back to the investigation stage to be dealt with by way of voluntary undertakings. When asked how he envisaged that a case such as that of Shipman in 1976 would be dealt with under the new procedures, Mr Scott said that the case would go to a FTP panel. The doctor might thereafter be invited to give voluntary undertakings. I shall comment on this proposed procedure shortly.

The 2003 Proposals

25.220 The 2003 draft Rules provided that the power to direct that an assessment of a doctor's health should be carried out would lie with the IC or a case examiner. They would exercise the power in a case where a question arose as to whether a doctor's fitness to practise might be impaired by adverse health.

25.221 The 2003 draft Rules provided that, if the assessment(s) showed that the doctor was (or might be expected in the future to be) not fit to practise, or not fit to practise save on a limited basis or under supervision, or both, the IC panel or a case examiner might then direct the Registrar to invite the doctor voluntarily to undertake to comply with certain conditions, which might include limitations on his/her practice. If the doctor gave the necessary undertakings, the IC panel or case examiner (if satisfied that the undertakings were being observed) would postpone further action on the case. The 2003 draft Rules would have given the IC panel or case examiner power to appoint one or more medical practitioners to supervise the doctor and to provide reports as necessary. The IC panel or case examiner would also have had power under the 2003 draft Rules to direct a further health assessment in order to determine whether it was necessary for the doctor to remain under the supervision of the IC panel or case examiner. The IC panel or a case examiner would also have been given power to invite the doctor to agree to the variation of the conditions with which s/he had undertaken to comply and, when appropriate, to release

the doctor from his/her undertakings. If the doctor refused to co-operate, or failed to comply with his/her undertakings or if his/her health deteriorated, the 2003 draft Rules would have given the IC panel or case examiner the power to refer him/her to a FTP panel.

25.222 All these arrangements would have been very similar to the arrangements under the old voluntary health procedures. The 2003 draft Rules gave the powers previously exercised by health screeners to both the IC and case examiners. In practice, however, it seems likely that the IC would have delegated one or more medically qualified case examiners to assume the role filled, under the old procedures, by the health screeners.

The 2004 Position

25.223 The May 2004 draft Rules removed the power to direct a health assessment from both the IC and the case examiners and placed it instead with the Registrar (in practice, the GMC staff). The only exception is that an IC panel may order a health assessment before taking a decision at an oral hearing relating to the issue of a warning. No explanation for this very important change (which has been retained in the November 2004 Rules) is apparent from the documents the Inquiry has seen and it appears that its objective must have been to reduce the workload of the case examiners and, thus, to reduce the number of additional case examiners who would be required to deal with the new arrangements for the double-handling of cases by both a medical and a lay case examiner. Another possible objective was to bring decisions to direct health assessments under staff control so that they could be subjected to financial restraints and service targets. With great respect to the staff – and I entirely accept that they are competent and hardworking and that some of them are very experienced – I cannot think that anyone could have reached a positive conclusion that the quality of decision-making by staff would be better than that by case examiners. Certainly, I am not aware of any evidence upon which such a view might be founded. In short, I cannot think of any reason of principle for making this change.

25.224 The sequence of events contemplated under the November 2004 Rules appears to be that the staff will direct a health assessment after a decision has been taken to refer a case to a case examiner. The staff may or may not confer with a case examiner before doing so. There is no requirement that they should. Presumably, if a case examiner thinks that there should be a health assessment, s/he will be able to request that one should be directed but s/he will not be able to insist. In my view, this rule should be changed so that case examiners (and an IC panel) can direct that a health assessment should be carried out. Indeed, it seems to me that, except in a case where an issue of health obviously arises and where it is clear from what branch of medicine the practitioner who is to carry out an assessment should come, the decision whether to order a health assessment and by whom it should be carried out should always be taken by a medically qualified case examiner rather than by a member of staff who is not medically qualified.

25.225 If the doctor fails to submit to or comply with an assessment of his/her health, the Registrar (or the staff exercising his legal powers) may refer the allegation for determination by a FTP panel. There is no requirement to consult with a case examiner before this is done. The FTP panel may then determine whether the doctor's fitness to practise is impaired and, if it is, may take appropriate action.

25.226 The May 2004 draft Rules implied (although they did not specifically provide) that, once the report of a health assessment had been received, the staff would, as a matter of course, refer the report to the case examiners. Under the July 2004 draft Rules (and now the November 2004 Rules), however, the Registrar (in practice, the staff) is given a discretion whether or not to refer an assessment report to a medical and a lay case examiner and need do so only if s/he considers it **'appropriate'** to do so.

25.227 I assume that the fact that the staff will have a discretion whether or not to refer an assessment report to the case examiners means that they can close the case if it appears to them that the assessment report discloses no evidence that the doctor's fitness to practise is impaired. The staff never made this kind of decision before. I am concerned about it. In my view, if a case warrants a health assessment, it also warrants a decision by a medically qualified case examiner. It may be that the July 2004 draft Rules and the November 2004 Rules have created a situation that was not intended. The Rules also suggest that the Registrar (or member of staff) can direct an assessment only after s/he has decided to refer the case to the case examiners. If, when the assessment report is available, it is not shown to the case examiners, it is difficult to see how the latter can conclude the case. In my view, this rule should be changed. If a case is to be closed on the basis of a health assessment received, the decision should be taken by case examiners, one of whom will be medically qualified, or by an IC panel.

25.228 If the staff refer the assessment report to the case examiners and the case examiners take the view that the doctor is not fit to practise, or is not fit to practise except on a limited basis or under supervision or both, or that the doctor has some condition which (though in remission at the time of assessment) may be expected to make him/her unfit to practise in the future, the case examiners may recommend that the doctor should be invited to comply with undertakings. The November 2004 Rules provide for case examiners – not the staff – to make the decision that undertakings should be offered. If the case examiners recommend that undertakings are appropriate, the Registrar (in practice, the staff) will write to the doctor, inviting him/her to agree to comply with the undertakings specified by the case examiners. If the doctor confirms that s/he is prepared to comply with undertakings, the case examiners must **'cease consideration'** of the allegation.

25.229 If, when they consider the assessment report, the case examiners agree that undertakings are inappropriate or inadequate for the protection of the public, they have power under the November 2004 Rules to refer the case to a FTP panel. The July 2004 draft Rules provided (and the provision has been retained in the November 2004 Rules) that a doctor should not be offered the opportunity to give voluntary undertakings where there is a realistic prospect that, if the allegation were referred to a FTP panel, his/her name would be erased from the register. This provision is designed to give effect to the observations of the Judicial Committee of the Privy Council in the case of Crabbie v General Medical Council[1], to which I referred in Chapters 21 and 23. If the case examiners cannot agree between themselves whether the case should be dealt with by way of voluntary undertakings, it will automatically be referred to an IC panel.

[1] [2002] 1 WLR 3104.

25.230 The May 2004 draft Rules provided (as do the November 2004 Rules) that it should be the Registrar (in practice, the GMC staff), and not the case examiners, who is responsible, in a case where medical supervision is required, for selecting the medical practitioners to act as supervisors and for requesting progress reports as necessary. There is no indication that those progress reports will have to be referred to case examiners. The staff will also assume responsibility for directing that further assessments should be carried out as and when necessary. The November 2004 Rules (like the July 2004 draft Rules) do not provide for any input from the case examiners into that decision. Again, it would appear that these changes in the arrangements are intended to reduce the workload of the case examiners.

25.231 Moreover, if a doctor fails to give the undertakings sought, or if his/her health deteriorates, or if information is received that otherwise gives rise to further concern regarding the doctor's fitness to practise, it is the Registrar (in practice, the GMC staff) who will have a discretion to refer the allegation for determination by a FTP panel. There is no requirement to consult with the case examiners before doing so. Decisions as to whether undertakings should be varied or should cease to apply will, however, be taken by case examiners.

Comment

25.232 I am very concerned about these arrangements. It is entirely appropriate that the staff should undertake the making of the practical arrangements for the medical and professional supervision of a doctor who is subject of voluntary undertakings, but it cannot be right that the overall responsibility for the doctor's progress should remain with a staff member. Under the old health procedures, a health screener was responsible for all decisions and provided professional expertise and continuity of attention. In Chapter 22, I reported the evidence of Dr Sheila Mann, who was a health screener from 1996 to 2004. I described the improvements to the health procedures that had been effected within the last few years. I thought (and I think that Dr Mann thought) that the new procedures would operate much as they had done in the past. Dr Mann said that it had been intended that one of the first batch of case examiners appointed should be a psychiatrist, in order to maintain continuity within the health procedures. However, as at December 2003, it had not been possible to recruit a suitable candidate. As a consequence, Dr Mann was concerned that there would not be a sufficient period of overlap to enable her to pass on the benefit of her experience to the new appointee. In March 2004, two of the recently appointed case examiners (one a professor of psychiatry) were appointed health screeners pending the introduction of the new FTP procedures. It is to be hoped that there was an opportunity for them to learn from Dr Mann's experience. However, as I have said, their future role will be very different from that of a former health screener. It is profoundly disappointing that the GMC should have abandoned its original plans, not, so far as I can see, for reasons of principle but for reasons of expediency. I hope that the GMC will think again. From what I heard from the evidence of Dr Mann, I am quite satisfied that a considerable degree of professional expertise is required in the interpretation of assessment reports. Also, some of the decisions to be taken are of a difficult and delicate nature. They affect the safety of patients and of the public. With all due respect to the staff members, whose competence I do not in any way seek to impugn, these decisions must be taken by appropriately qualified medical practitioners.

Cases with a Performance Element

25.233 The new procedures for dealing with cases where an allegation suggests that a doctor's professional performance is deficient are essentially very similar to those for dealing with health cases. In December 2003, Mr Scott told the Inquiry that he could not imagine that what were then termed the 'performance procedures' would operate in anything like the same way in the future as they had in the past. He said that, following a challenge to a doctor's fitness to practise, a case examiner would consider whether it was necessary or appropriate to order a review of the doctor's performance. If a performance assessment were undertaken and if the assessment report showed deficiencies in performance and the doctor accepted a statement of requirements, the case would go into 'consensual disposal' and would not go to a FTP panel unless the doctor was uncooperative. The arrangements for 'consensual disposal' would be very similar to the old voluntary performance procedures. It appears that what Mr Scott had in mind when he said that the performance procedures would be different in the future was not that the practical arrangements would be different but that the underlying philosophy would change. During their evidence to the Inquiry, both Mr Scott and Sir Graeme Catto voiced the intention that the GMC should move away from focussing on the remediation of doctors referred to it and should instead direct its attention towards 'cases where restriction on registration was appropriate'.

25.234 As with health cases, the power to take a decision to direct an assessment of a doctor's performance will, under the November 2004 Rules, lie with the Registrar (in practice, GMC staff) and not, as it would have done under the 2003 draft Rules, with the case examiners or the IC. This is a particularly significant change since, at the time when the new FTP procedures were being formulated, there was doubt about whether the IC would delegate the power to make that decision even to a medically qualified case examiner. It was anticipated that the IC would retain for itself the power to decide whether a performance assessment should be undertaken, at least in some cases. It was intended, however, that, in time, the IC would delegate such decisions to one or more case examiners. That was the situation which appears to have been envisaged by Mr Scott, when he gave evidence to the Inquiry. He spoke as if the case examiners would be taking these decisions. However, their job description did not mention this function.

25.235 Prior to the May 2004 draft Rules, it was the intention that the IC would assign medically qualified case examiners to take over the role played by the performance case co-ordinators in the old performance procedures. Once a performance assessment had been undertaken and had concluded that a doctor was not fit to practise or not fit to practise save on a limited basis or under supervision or both, a case examiner would have taken over the management of the case. Under the 2003 proposals, the voluntary performance procedures would have remained much the same as under the old procedures, save for some simplification of the procedures by eliminating referrals to, and hearings by, the Assessment Referral Committee.

25.236 This approach has now been changed and, under the November 2004 Rules, the power to direct a performance assessment will lie with the Registrar (in practice, the GMC staff). Indeed, neither case examiners nor the IC will have any power to order such an

assessment save only that an IC panel may order a performance assessment before taking a decision at an oral hearing relating to the issuing of a warning. The powers and function of the staff and case examiners are virtually the same where a performance assessment has been undertaken as when an assessment of health has been carried out. The only difference is that, where a doctor fails to comply with the reasonable requirements of the performance assessment team, the staff will have the power (without consultation with case examiners) to refer the case to a FTP panel for consideration of suspension of the doctor's registration or of the imposition of conditions on his/her registration.

25.237 One possible outcome of a case where a performance assessment has been carried out will be the issuing of a warning. A warning is likely to be considered by the case examiners in a case where an assessment report raises a significant cause for concern about a doctor's practice but not concerns of such magnitude as to warrant referral to a FTP panel. I am concerned about this proposal. Logically, if there is significant cause for concern, the case will have passed the investigation stage test that I have proposed and will warrant referral to a FTP panel. The case examiners or IC could, as an alternative to referral to a FTP panel, invite the doctor to agree to voluntary undertakings. Such a course would be preferable to the issue of a warning. If a warning is issued, there will be no one to follow up the cause for concern and to see whether the doctor has done anything to rectify his/her shortcomings. It may be said that the warning will be communicated to the employer or PCO who will then be responsible for supervision. That may be so and it may be well done or not. However, the GMC will have relinquished responsibility, notwithstanding the existence of 'significant cause for concern'.

Comment

25.238 Under the November 2004 Rules, in cases where a performance assessment has been carried out and where voluntary undertakings are given, the GMC staff will take over many of the functions which, under the old procedures, were exercised by medically qualified performance case co-ordinators. This is a very significant departure from the old arrangements and from those proposed in 2003. It is likely to have a considerable impact on the future operation of the performance procedures.

25.239 I have already expressed my concern about the changes to the health procedures which I believe will be detrimental to the quality of supervision provided by the GMC. The same concerns arise, for much the same reasons, in respect of the changes to the performance procedures. The professional expertise applied and the continuity of case management by medically qualified case co-ordinators, which were good features under the old procedures, will be lost. I am particularly concerned at the prospect that the staff will be able to close a case without referring it to case examiners. But that is not the only problem. I see from the November 2004 draft Investigation Manual that it is intended that there should be a team of staff dedicated to the provision of performance assessments. So be it. Arranging an assessment is an appropriate function for the staff. Deciding whether there should be one is another matter. Assessments are expensive and a staff member might be put under pressure not to order an assessment for financial reasons. Indeed, there are real reasons to fear that that might be so. The November 2004 draft Investigation Manual

refers to **'performance against service targets'** in respect of both health and performance assessments.

Disclosure of an Assessment Report to a Doctor's Employer or Primary Care Organisation

25.240 One very welcome development that was introduced in the May 2004 draft Rules was a requirement that, on receipt of the report of an assessment of a doctor's performance, the Registrar should send a copy, not only to the doctor him/herself but also to any person by whom the doctor was employed to provide medical services or with whom s/he had an arrangement to do so. Concern had been expressed at the Inquiry's hearings (and by the Performance Procedures Review Group, chaired by Dame Deirdre Hine, which reported to the GMC in April 2004) that this information was not given to those persons and bodies with local responsibility for doctors. The report of the Review Group had observed that a performance assessment report **'cannot be regarded as a private document between the GMC and the doctor'**. Receipt of the assessment report would have enabled employers and PCOs to have a better understanding of the nature and extent of the doctor's problems and to make an informed decision about the steps they should take to deal with those problems.

25.241 However, this provision was omitted from the July 2004 draft Rules and does not appear in the November 2004 Rules. In its place is a much more limited provision, whereby details of any relevant undertaking (save any relating exclusively to the doctor's health) will be disclosed to employers and PCOs and to any enquirer. This was done under the old procedures. There is now no mention of disclosure of assessment reports to employers and others. The proposal appears to have been dropped.

Comment

25.242 This is extremely disappointing. It is difficult to see how local NHS bodies can properly discharge their clinical governance obligations if they do not have access to this kind of information about the doctors for whom they are responsible. I have found no reference to this change of direction in the briefing papers distributed to Council members prior to the meeting in July 2004 at which the July 2004 draft Rules were approved. I know of no explanation for the change. I can see that information about undertakings is of some value but it cannot compare with the usefulness of the assessment report itself.

Cancellations of Referrals to a Fitness to Practise Panel

25.243 As I have explained in Chapter 20, in 2002, 20% of all referrals by the PPC to the PCC were subsequently cancelled by the PPC. Under the old FTP procedures, a decision to cancel required the agreement of the PPC. The complainant had to be consulted about the proposal to cancel; however, this was done only if the complainant was a private individual and not if the case had been referred to the GMC by a public body.

25.244 It is obviously important that cases that have been properly referred for a disciplinary hearing should not be cancelled without good reason.

The 2003 Proposals

25.245 Under the 2003 draft Rules, where the Presenting Officer (usually a solicitor or counsel instructed by the GMC to present the case before the FTP panel) considered, in the light of any evidence which had become available to him/her, that the fitness to practise of a doctor whose case had been referred to a FTP panel or an IOP was not impaired or that, for some other reason, the proceedings before the panel should not be held, s/he could have asked the IC or a case examiner to reconsider the case with a view to cancelling the referral to a FTP panel. It would have been open to the IC, had it wished, to delegate to a case examiner the task of deciding whether the referral of a case should be cancelled. No notice of the request to cancel a referral had to be given, either to the doctor or to the maker of the allegation. Nor was any guidance given as to how the task should be undertaken.

The 2004 Position

25.246 The May and July draft 2004 Rules contained significant changes to the proposed arrangements for the cancellation of a referral to a FTP panel or an IOP and these have been retained (with some further alteration) in rule 28 of the November 2004 Rules. A decision to cancel a referral is now to be initiated, not by the Presenting Officer, but by the Registrar (in practice, a member of the GMC staff). That member of staff may refer the case for a decision to any member of the IC (i.e. presumably, under the new arrangements for the composition of the IC, any person whose name appears on the list of persons eligible to sit on an IC panel, including some members of the GMC) or to the President. Those persons will be able to act alone and without consultation with others. The discretion given to them will be very wide. The November 2004 Rules permit a decision to cancel a hearing to be made, *inter alia*, if evidence becomes available (the May 2004 draft Rules would have required that the evidence be **'new'** but the July 2004 draft Rules and the November 2004 Rules removed that requirement) that suggests that a doctor's fitness to practise is not impaired or **'if it appears that for some other reason, the hearing before the Panel should not be held'**. There is still no requirement to notify the maker of an allegation that a cancellation is being considered, still less to consult him/her on whether this should be done. Once the decision has been made, rule 28 requires the Registrar to serve notice of the decision, together with the reasons for it, on the doctor and the maker of the allegation.

Comment

25.247 I am very concerned about this new rule for several reasons. First, the grounds on which the discretion exists to cancel a case are extremely wide. They could cover almost any eventuality. For that reason, the power of cancellation is open to abuse. It might be used where somebody (either a member of the administrative staff or a GMC member or another case examiner) is of the opinion that the case examiners' decision to refer a particular case to a FTP panel was wrong. Provided that a member of staff is willing to initiate the request (and it might be difficult for him/her to refuse if asked), any IC panellist will be able to cancel a referral with no formality whatsoever, without consulting any other member and without even notifying the maker of the allegation. I am concerned that GMC staff, worried about a backlog of FTP panel hearings or about some difficulty in arranging a hearing date

or the attendance of witnesses, might invite an IC panellist to cancel a hearing. It is even more worrying to think that it might become known which panellists were prepared to comply with such requests so that they could be 'hand-picked'.

25.248 In a recent letter to the Inquiry, the GMC said that the power of cancellation would be used **'in a small proportion of cases'** where the GMC's lawyers had advised that the case had no merit and that the hearing should not proceed. However, the Rules, as currently drafted, do not provide that the initiative to cancel a hearing should come from a lawyer, as the 2003 draft Rules did. It seems, therefore, that it must now be envisaged that a cancellation could be initiated by a non-legal member of staff. I am unsure what was meant by the assurance that the power of cancellation would be used in only a small proportion of cases. It was used in as many as 20% in 2002. I can see that improved investigation in the early stages should result in there being fewer cases where evidential problems arise after referral to a FTP panel. However, it remains to be seen how many cancellations will occur under the new procedures.

25.249 In my view, this rule should be changed. Cancellation of the hearing of a case that has been properly referred should not be undertaken lightly; nor should it be done in obscurity. Such decisions should be taken by a panel of the IC after careful consideration and the reasons for the decision should be formally recorded. The reasons given should be specific to the case and should not be general or formulaic. Both the doctor and the person making the allegation should be notified some time before the meeting at which the matter is to be considered and should be told why cancellation is to be considered. They should have the opportunity to make representations.

25.250 Whether the GMC adopts the changes I have suggested or resolves to continue with the arrangements it has currently made, there must be very careful monitoring and audit of the numbers of cancellations applied for and granted and the reasons for the decisions. These numbers and the reasons (anonymised as appropriate) should be placed in the public domain on an annual basis. In the past, the number of cases cancelled after referral did not usually feature in the GMC's annual FTP statistics. That was not acceptable as it provided an incomplete picture of what was actually happening.

Consensual Disposal of All Categories of Case

25.251 At its meeting in May 2004, the Council agreed that the GMC should request legislation to enable it to deal with all categories of case by means of 'consensual disposal arrangements', i.e. by the doctor giving voluntary undertakings about his/her future conduct or practice. Under the existing Rules governing the new procedures, such consensual disposal will be available only in cases involving a health or performance element. However, if the new proposal is brought into effect, conviction, caution and determination cases – as well as allegations of misconduct – could be disposed of by means of voluntary undertakings. The GMC is to ask the DoH to effect the necessary amendment to the legislation by way of an order under section 60 of the Health Act 1999. Meanwhile, there is to be consultation and detailed work is to be carried out on how such consensual disposal might operate.

Comment

25.252 It may be premature for me to comment but I think it would be helpful if I expressed my concerns about this proposal. My first concern is that cases dependent upon reports of convictions, determinations by another regulatory body and allegations of misconduct must, in my view, be dealt with in the public domain. I fear that 'consensual disposal' may take place in private. Second, I am concerned, particularly in respect of allegations of misconduct, that there may be no adequate resolution of the issues in dispute. In health and performance cases, there will be assessment reports which set out the nature and extent of the doctor's impairment of fitness to practise. This will not be so in a case of misconduct. Insofar as there is a dispute about the facts, there is a real danger that the factual issues will be 'fudged' by the GMC accepting the doctor's account of events, including all the mitigation. It may do so in order to avoid the cost and effort of a contested hearing. It may accept proffered undertakings – much as happened in some cases under the voluntary health procedures – on the ground that it is better for the public to be protected by voluntary undertakings than to take the risk that a FTP panel might find that the doctor's fitness to practise was not impaired or not sufficiently impaired to warrant the imposition of conditions on his/her registration. In my view, the GMC should proceed with extreme caution down the route to consensual disposal in all types of case, at least if the intention is, as I understand it to be, to operate such procedures in the investigation stage.

25.253 If there is to be consensual disposal in cases of misconduct, conviction and determination, there must be a hearing before a FTP panel sitting in public. In effect, such disposal must take place at the adjudication stage and not as part of the investigation stage. In conviction and determination cases, the FTP panel should be made fully aware of the underlying circumstances. The way in which this could be done might vary according to the nature of the proceedings. There might be a transcript of the previous proceedings. A police officer might give evidence of the circumstances of a conviction. In misconduct cases, there should be an agreed statement of facts on which the maker of the allegation should be entitled to comment in writing. The FTP panel should see both the statement and the representations so that, if it appeared that there was a significant dispute of fact, a full hearing could be held. The agreed statement should be put in the public domain. The FTP panel should have all relevant facts in the GMC's possession, including of course any previous FTP record. The FTP panel should satisfy itself that the proposed undertakings are sufficient to protect the public and to reflect the gravity of any offence. Afterwards, the doctor's compliance with his/her undertakings should be monitored and there should be provision for returning the case to the FTP panel in the event of a breach. However, this procedure would differ very little from the procedure now followed, where the doctor makes admissions and conditions are imposed.

Revival of Allegations

25.254 Under the old procedures, conviction cases and cases involving complaints about a doctor's conduct which had been closed by the screeners or by the PPC could be 'revived' if the GMC subsequently received notice of another conviction or complaint

about the same doctor. The Rules provided for a 'limitation period' of two years, after which an earlier report or complaint could not be revived. In Chapter 20, I questioned whether such a comparatively short period adequately protected patients. Cases involving complaints about performance could also be revived; no limitation period was specified in the Rules but, in practice, the GMC operated a 'cut-off' after three years.

25.255 In November 2001, when the new procedures were being developed, it was agreed by Council that it should be possible for a complaint closed at the initial stages of the procedures to be revived in the event of a new complaint being received. However, no such a provision appeared in the 2003 draft Rules, or in any subsequent draft. The November 2004 Rules make no specific provision for revival of allegations.

25.256 It seems to me that there should be proper provision for the revival of allegations previously closed. One can readily imagine circumstances in which an allegation which seemed relatively minor at the time it was considered assumes greater significance when another similar complaint is received subsequently. This is particularly so in cases involving allegations of deficient performance. It is important in the interests of patient protection that the GMC should, in those circumstances, be able to look at the picture as a whole, rather than being artificially limited to consideration of the subsequent allegation only. If there is to be revival of closed allegations in certain circumstances, it is important that the relevant provisions are contained in the Rules – not least so that doctors may be aware of the possibility of an allegation against them being reopened and of the circumstances in which this might be done. It is, in my view, entirely appropriate that there should be a limitation period after which it should not, save in wholly exceptional circumstances and in the interests of patient protection, be appropriate to reopen a previous complaint. I would suggest that that period should be significantly greater than the two or three years previously operated. I would suggest a period of five years.

Review of Investigation Stage Decisions

The 2003 Draft Rules

25.257 Under the 2003 draft Rules, IC panels and case examiners were to have the power to review one of their own decisions to refer or not to refer a case to a FTP panel or to dispose of the case by means of a warning. Such a review was to take place only where new evidence or information had become available which made such a review desirable for the protection of members of the public or otherwise in the public interest. The doctor was to be consulted and the IC panel or the case examiner was to take into account the doctor's interests, in addition to the public interest. There was no provision in the 2003 draft Rules for the maker of the allegation to be consulted about the proposal to review a decision – not even a previous decision to refer the case to a FTP panel – even though that person might have been in a position to comment on the new evidence or information and would plainly have had an interest in knowing that a review was to take place.

Discussion at the Inquiry

25.258 There was some discussion at the Inquiry seminars in January 2004 about the need for a speedy means of review of decisions taken at the investigation stage. In the past, the great

majority of cases reported to the GMC have been closed at a preliminary stage and in private, and it is anticipated that that will continue under the new procedures. It was thought, therefore, that, if public dissatisfaction were to be avoided, there should be some means of reviewing decisions to close cases taken at a preliminary stage. There was a large measure of agreement that such a review should be available both to the maker of the allegation and to the doctor concerned. However, most participants were of the view that the right of a doctor or maker of an allegation to seek a review should be circumscribed in some way. It was feared that, if doctors and complainants had an automatic right of appeal, the GMC would be inundated with unmeritorious applications. I can see the force of that. However, the Inquiry heard that, in the Canadian Province of Québec, any complainant who is dissatisfied with the preliminary decision of the body performing the equivalent 'screening' function to that of the investigation stage of the new procedures (the Inquiry Division of the Collège des Médecins du Québec) is entitled to a review by a review panel. Apparently, there is no problem with inundation there. It appears that, if a decision is taken at the 'screening' stage not to refer a case to a disciplinary hearing, the complainant receives a letter setting out the reasons for the decision in detail. I suspect that it is because the complainant receives a full and detailed explanation of the reasons for the decision that there are not too many unmeritorious applications for review.

The 2004 Position

25.259 The proposed provisions governing reviews changed in 2004. The July 2004 draft Rules removed the power of review from IC panels and case examiners and limited the decisions that will be susceptible to review. This remains the position under the November 2004 Rules. They provide that the President (and only the President) may review a decision not to refer an allegation to a FTP panel, a decision to issue a warning, or a decision by the case examiners to accept a doctor's voluntary undertakings following a health or performance assessment. There can be no review of a decision by an IC panel or case examiner to refer a case to a FTP panel. Nor, as I read the Rules, may the President review a decision by the Registrar (or member of staff) not to refer a case to a case examiner.

25.260 There are only two grounds on which a review will be granted. One is that there is information that the GMC has erred in its administrative handling of the case and a review is necessary in the public interest. The second is that there is new evidence or information which makes such review necessary for the protection of the public or for the prevention of injustice to the doctor, or that a review is otherwise necessary in the public interest. It follows that any doctor or maker of an allegation whose request for a review does not fall within those narrow limits but who is nevertheless dissatisfied with the decision will have to apply for judicial review. I am disappointed that the GMC has not felt able to act upon the experience of the Collège des Médecins du Québec, Montreal, and to offer an unfettered right to a review. If, as the GMC intends, makers of allegations which are not going to proceed to a hearing will receive a full letter of explanation of the decision, together with a copy of the CEDF, it would seem that there would be no real danger of an inundation.

25.261 The doctor and the maker of the allegation must be notified of a decision by the President to review a case and must be provided, where appropriate, with copies of any new

evidence received. The November 2004 Rules require that their representations on the proposed review must be sought. Where the President decides to review a decision, he may determine that the original decision should stand or he may refer the allegation to two case examiners for consideration as if it were an allegation being considered by them for the first time.

25.262 The decision on a review must be notified to the doctor concerned and to the maker of the allegation, together with any other person whom the Registrar considers to have an interest in receiving notification.

Comment

25.263 These new arrangements are in some respects a definite improvement on the 2003 proposals. The fact that the maker of the allegation is now involved in this process is a most welcome change. Also, the decision has been taken away from the IC or a case examiner. To have left it in their hands would not have been satisfactory, as there would have been no 'fresh look' at the case. Another improvement is that it is not possible under these provisions to review a decision to refer an allegation to a FTP panel. That is welcome, although it may increase the danger of surreptitious cancellations, about which I expressed my concern in paragraph 25.247. I am, however, concerned about the provision that the President alone should exercise these powers personally. There are two reasons for this: one of principle, one of practicality. There would be much to be said for giving the power of review to someone outside the GMC. It would allay public concern that the GMC is a 'closed shop' and protects doctors. It would also provide a useful means of external audit. The second reason is that the role of President is already extremely demanding and I do wonder whether it is sensible to impose upon him this additional burden. The amount of work that will be involved is, as yet, uncertain. Some case files are several inches thick. If the President is to reach a personal decision in each case, as opposed to ratifying a decision suggested by a member of staff, he will have to read the whole case file, possibly including close examination of medical records or a performance assessment report. He might find himself driven to delegate the task to others.

25.264 As I mentioned above, it appears that the present provisions do not allow for a review to right an error made by a member of staff in rejecting an allegation at the earliest stage, before referral to a case examiner. If so, this *lacuna* should be remedied.

Interim Orders

25.265 As I explained at paragraph 25.23, IOPs will take the place of the old IOC. The November 2004 Rules provide that it will be open to the Registrar at any stage to refer an allegation to an IOP for consideration of the making of an interim order. A single case examiner may direct the Registrar to refer a case to an IOP. The November 2004 Rules do not contain any similar power for the IC. However, the Guidance accompanying the draft Rules suggests that it will be open to the IC to make a **'recommendation'** that a case should be referred.

25.266 Hearings before an IOP will generally be in private, unless the doctor requests otherwise, or the IOP considers it appropriate for one of a number of reasons to hear the case in

public. An IOP may impose an interim order for a period of up to 18 months. Orders will be subject to periodic review.

The Adjudication Stage

25.267 I shall now consider the processes undertaken at the adjudication stage. I shall begin by examining the composition of the FTP panels which will hear allegations that have been referred to the adjudication stage.

Fitness to Practise Panels

The Composition of the Panel

25.268 As I have already said, GMC members will not be eligible to sit on FTP panels. However, the panels will work within an organisational and policy framework established and supported by the GMC. Panels will be composed of associates, some medically qualified and some not. They will be appointed, selected and trained by the GMC, which will also manage, monitor and appraise their performance. Continued service as a member of a FTP panel will depend on performance being satisfactory.

25.269 Panels will be chaired by panellists who have undergone assessment and have been appointed to act as chairmen. Chairmen may be medical or lay. At the Inquiry seminars, there was some discussion about the wisdom of having a legally qualified chairman. I discussed this issue in Chapter 21 and also drew attention to the recommendation of Miss Jean Ritchie QC in her report into the conduct of Rodney Ledward. She expressed the view that the chairmen of PCC panels should be legally qualified. Plainly, FTP panels need legal advice and expertise. In the past, this has been provided by a legal assessor and, in the immediate future at least, it is intended that this should remain the case. Some legal assessors are no doubt very good. I have also seen transcripts of advice given by legal assessors that has been unclear or even frankly wrong. Even if the legal assessor is completely competent, there are limitations on the role s/he can play. He or she cannot direct the course of the FTP panel's deliberations so as to ensure that matters are considered in a logical order and that only evidence relevant to the issue under consideration is taken into account. It is difficult to teach these skills to a non-legal chairman who may sit on a GMC panel only a few times in a year. Also, as I observed in Chapter 21, the GMC has to teach its chairmen how to conduct a hearing and what to say at each stage of the proceedings. Such matters would be second nature to a legally qualified person.

25.270 In November 2001, the Council agreed (by 36 votes to 35) that, under the new procedures, FTP panels hearing conduct cases which met appropriate criteria should have a legally qualified chairman. It was envisaged that a legally qualified chairman would be appointed in long or complex cases, in cases involving many difficult legal or procedural issues and in certain high profile or particularly controversial cases. A decision as to whether a legal chairman should be appointed would be taken at the case management stage. Internal GMC documents show that the November 2001 decision was still extant a year later. In May 2003, Council agreed that, if a legally qualified chairman was appointed to chair a

hearing of a conduct case, a legal assessor should also be appointed. Since May 2003, it appears that the intention to use legally qualified chairmen has been abandoned. Sir Graeme Catto told the Inquiry that the GMC had discussed the idea of using legal chairmen in the recent past and had decided to 'leave that option open'. He said that some associates eligible to sit on PCC panels were legally qualified; he did not know whether any of them have ever chaired a panel.

25.271 My view on this issue is that, if the GMC retains control of the adjudication stage, it should enrol some legally qualified chairmen and should try them out, starting with the more complex cases. If they are found to be a success, the practice could be extended. It seems to me that the new procedures are bound to throw up new legal points. Some of them might well be complex. The presence of a legally qualified chairman might help to ensure that decisions on such points were right, from the start. If the idea were taken up of having a corps of panellists who would sit on cases from all the healthcare regulatory bodies, it would be possible to have full-time legally qualified chairmen.

25.272 In addition to a legal assessor, FTP panels may, in a case involving a health or performance element, receive advice from one or more specialist health advisers or specialist performance advisers selected by the Registrar from a panel maintained for the purpose. A legal quorum for the FTP panel will be three, including at least one lay and one medical panellist. GMC staff will act as secretaries and clerks to the FTP panels. The September 2004 draft Guidance for Panellists suggests that a doctor will be able to apply for a specialist adviser to be appointed in a case including allegations of misconduct. I think this must be intended to provide panellists with advice about the practice and standards to be expected within a particular medical specialty.

Notice of Referral to a Fitness to Practise Panel

25.273 Following a decision to refer a doctor to a FTP panel, s/he will be sent a notice of referral containing certain specified information. The November 2004 Rules provide that the allegation(s) and the facts on which it/they are based must be particularised. The 2003 draft Rules had merely required them to be summarised. It is a fundamental rule of natural justice that a person facing any form of disciplinary process must have adequate notice of the charges s/he is to face. If a doctor is facing a specific allegation of misconduct, it is vital that s/he is told exactly what is alleged. However, it does appear to me that, in some types of case (for example, one that depends to a large extent upon a performance or health assessment), it would be sufficient if the doctor were to be told (adopting the words of the adjudication stage test proposed by the GMC) that it was alleged that his/her fitness to practise was impaired (to a degree justifying action on registration) by reason of the matters contained in the assessment report. Even in conduct cases, I doubt that the degree of particularity that appears to have been given in the past is necessary for the giving of proper notice to the doctor. Reading some PCC decisions, it appears that the proceedings have been broken down into the consideration of every single element which must be proved in order to support the allegation of SPM. I do wonder whether this is really necessary; it fosters the impression that these are criminal proceedings, whereas they are not.

25.274 The Guidance accompanying the July 2004 draft Rules stated (and the passage appears also in the Guidance accompanying the November 2004 Rules):

> **'Where appropriate, the GMC will also notify the practitioner of the outcome it will be seeking at the relevant hearing.'**

25.275 This process is not provided for in the Rules. The thinking is that it will be helpful and fair to doctors. In effect it lets them know the worst that could happen to them. I can see that an indication that the GMC is not seeking erasure or suspension might encourage a doctor to make admissions, secure in the knowledge that the worst that can happen is the imposition of conditions or restrictions. He or she might even be able to negotiate a set of conditions which could be entered into voluntarily. However, it does seem to me that there are real disadvantages in such a practice. In the first place, once the GMC has pitched its desired outcome at a certain level – say, the imposition of conditions – it will be extremely difficult for a FTP panel to impose a more serious sanction. The effect will be to tie the panel's hands. Second, an early indication of the desired outcome is likely to colour preparations for the hearing by both the doctor and the GMC. If the FTP panel were determined to take a different view, there would be the potential for unfairness to the doctor. Third, I remind the reader that, when the GMC was thinking about the form of its new procedures, it wished to create some real separation between the adjudication and investigation functions. It chose to keep the investigation function in-house and the FTP panels were supposed to have some real independence. In fact, they have precious little. Panellists are to be selected, appointed, trained, issued with guidance, appraised and possibly dismissed by the GMC. If, in addition, the GMC seeks effectively to impose an upper limit on the sanction available in an individual case, the independence of FTP panels will be further reduced.

25.276 Moreover, it appears that the present proposals may go beyond the giving of an indication as to what sanction the GMC will seek. **'Outcome'** could include the giving of undertakings which might be accepted without any findings of fact or decision about impairment of fitness to practise. I have already expressed my views about the need, in the public interest, for clarity in the resolution of cases involving misconduct, convictions and determinations.

25.277 I think that the GMC should think again about this whole idea. I do not think that any indication of the GMC's preferred outcome should be given in advance of the hearing. It would create an expectation on the part of the doctor which, if not fulfilled, would be unfair to him/her and which, if fulfilled, may not provide adequate protection for patients. Moreover, it may be that, if the case is contested, it becomes more serious as the evidence unfolds. If the GMC is to put forward its views on the appropriate outcome, this should, in my view, be done, as it has been done in the recent past, at the hearing before the FTP panel. If this course is followed, it should be made clear to all that the GMC is only making a submission and that the FTP panel is under no obligation to heed it.

25.278 The Guidance accompanying the November 2004 Rules is silent on the question of who at the GMC is to decide what outcome the GMC will be seeking in any individual case (although the Registrar is given responsibility for serving the notice of referral). I do not know who it is intended should decide where the desired outcome is to be pitched. I am

not aware of any provision in the Rules relating to the old or the new procedures that entitles any particular person or panel or committee to make such decisions. If a decision of this importance is to be made, the person or body making it should be formally authorised to do so on the GMC's behalf and proper criteria for such decisions should be agreed and published.

25.279 The September 2004 draft Guidance for Panellists gives no advice about how FTP panellists should approach cases where the GMC has given an indication of the desired outcome. Indeed, it does not mention the fact that such an indication might be given. These are important matters on which guidance should surely be given.

Evidence Gathering

25.280 The November 2004 Rules do not appear to contain any specific provision for further investigation of a case after referral to a FTP panel. The Guidance which accompanies the November 2004 Rules says that, before sending out a notice of referral, the Registrar will undertake such further investigations (including instructing solicitors to procure witness statements and other documentary evidence) as are necessary for the satisfactory presentation of the GMC's case at the hearing. In my view, there should be enshrined in the Rules a specific power to investigate further. This should empower the GMC to require the production of any evidence, documentary or otherwise, in the event that anyone might seek to impede such investigations.

Case Management

25.281 In the past, considerable problems arose with the arrangements for hearings before PCC panels. There was no formal mechanism for case management. As a consequence, there were no proper arrangements for disclosure of evidence and no reliable means of ascertaining the likely length of cases or of scheduling them at times when the parties and witnesses were available. This led to the frequent adjournment of cases, with consequent inconvenience, delay, expense and, no doubt, distress both to witnesses and to the doctors concerned. In the recent past, some informal management of cases referred to a PCC panel was undertaken. However, participation was entirely voluntary. A very welcome aspect of the new procedures is the introduction of a formal system of case management with pre-hearing case management reviews.

25.282 The case management provisions apply to initial referrals to a FTP panel and also to subsequent hearings to review a case (where a doctor's registration has been suspended or made subject to conditions) and to applications for restoration of a doctor's registration. The case management reviews will be conducted by a legally qualified Case Manager. The November 2004 Rules provide that the Case Manager should act independently of the parties. He or she is to be a quasi-judicial figure, who will be contracted part-time by the GMC to deal with case management reviews. Case management reviews will usually take place by telephone conference. The Case Manager will give directions to secure the **'just, expeditious and effective'** running of the hearing before the FTP panel.

25.283 The November 2004 Rules set out detailed provisions for one or more case management reviews in advance of a FTP panel hearing. The provisions (which have been extensively

revised since they first appeared in the 2003 draft Rules) cover such matters as the disclosure of documents, exchange of witness statements, exchange of expert evidence, and exchange of skeleton arguments. They also cover the provision of time estimates and suggested dates for hearings. They provide for the parties to state whether the health of the doctor is to be raised as an issue and for the doctor to give prior notification of the extent to which facts and evidence are admitted. There is provision for the Case Manager to direct the parties to provide a statement of agreed facts in a case where an allegation is admitted. In short, the case management provisions should enable the parties and members of the FTP panel to prepare properly for hearings, should avoid the unnecessary attendance of witnesses and should reduce to a minimum the frequent adjournments which were in the past made necessary by the late disclosure of important evidence.

25.284 The November 2004 Rules also provide for certain 'automatic' directions to take effect in the absence of any direction by a Case Manager or of agreement by the parties to the contrary. These are applicable to hearings by both FTP and IC panels. These directions require each party not less than 28 days before the date of the hearing to provide to the other party a list of every document which s/he proposes to introduce as evidence, together with a copy of every document which the other party has not previously received. They also require each party to notify the other, within 14 days of receiving the list, whether or not s/he requires any person to attend to give oral evidence in relation to the subject matter or making of any document. Even where one party notifies the other that s/he requires a person to attend, the IC or FTP panel has discretion to dispense with the need for oral evidence in certain circumstances.

25.285 The November 2004 Rules provide that a FTP panel may draw such inferences as it considers appropriate in respect of the failure by a party to comply with directions issued by the Case Manager. There had been concern that the case management provisions would have no 'teeth', since there was no sanction available if directions were not complied with. It was suggested that the risk that adverse inferences might be drawn from the result of non-compliance should be a deterrent. It was also suggested that a party who failed to comply might be penalised in costs. However, it appears that the idea of imposing a penalty on costs has not been adopted; instead, the drawing of adverse inferences is to be allowed. The Guidance which accompanies the November 2004 Rules states that failure to comply with the directions of the Case Manager might lead, not only to the drawing of adverse inferences, but also to evidence not being admitted at the FTP panel hearing. That provision is not in the Rules, although I suppose it might be said that an IC or FTP panel has a discretion to refuse to admit any evidence for good reason. I am rather concerned about the provision that an adverse inference may be drawn against a party who has failed to comply with a case management order. I would have thought that it would be proper to do that only in a most exceptional case, where a flagrant refusal to comply is consistent only with the desire to conceal a particular piece of evidence. In general, I would have thought it dangerous to draw adverse inferences from what may be no more than a failure to comply due to incompetence and disorganisation. One must not lose sight of the objective of the proceedings, which is to arrive at the truth. I think that a penalty in costs would usually be more appropriate. That can sometimes teach an incompetent solicitor to do better in future. If such a penalty were available against a doctor, it would have also to be available against the GMC.

Comment

25.286 Taken as a whole, I regard these new case management provisions as a very good idea. However, their effectiveness will be directly related to the amount of effort that is put into them by the Case Managers. In the course of my work as a judge, I have seen many case management orders which simply follow a standard form and are not adequately tailored to the specific circumstances of the case. That is a danger where automatic directions are allowed to operate or where the parties are allowed to agree an order. Good case management requires that the judge (or Case Manager) has the time and inclination to read the papers thoroughly, to get a clear grasp of the issues, to ask a lot of questions about the way in which the case is to be presented and to make orders that will ensure that the parties are ready with their evidence and that no one is taken by surprise. I hope that these provisions will have the desired effect. The work of Case Managers should be audited to ascertain the extent to which they achieve their objective of avoiding adjournments, disrupted hearings and the unnecessary attendance of witnesses.

25.287 The Guidance accompanying the November 2004 Rules suggests that case management reviews may not be necessary for cases which rely to a large extent on health or performance assessments. I recognise that the GMC has a good deal of experience of such cases. However, I must say that the impression I have, from reading the transcripts of one or two performance cases, is that a case management review would have been most helpful. Miss Jackie Smith, Head of the Performance Section, told the Inquiry about one performance case in which the doctor had called 36 witnesses. I would have thought that robust case management might have helped to avoid such a situation.

The Hearing: the Parties

25.288 The November 2004 Rules state that the 'parties' to a hearing before a FTP panel are the GMC and the doctor, or their respective representatives. Under the new procedures, it will no longer be open to the maker of an allegation to present the 'prosecution case'. Doctors are expected to attend hearings. They are entitled to be represented by counsel or a solicitor, or by a representative of their professional organisation, or, in certain circumstances, by a member of their family or another person. The GMC will be represented by the Presenting Officer. If the doctor does not appear, the FTP panel may, in certain circumstances, proceed to hear the case in his/her absence.

The Hearing: Public or Private

The 2003 Proposals

25.289 The 2003 draft Rules provided that, except where considering a health allegation (and in certain other special circumstances), a FTP panel must sit in public. The Guidance which accompanied the 2003 draft Rules, however, stated that, where a FTP panel was considering an allegation of adverse health or of deficient performance, the presumption was that the case should be heard in private. The proposals at that stage, therefore, created uncertainty as to whether it was intended that a case involving an allegation of deficient performance should be heard in public or in private. This topic had been the subject of debate within the GMC for some time.

The 2004 Position

25.290 The November 2004 Rules provide that hearings before a FTP panel should in general take place in public. They provide that a hearing before a FTP panel should be in private when the panel is considering a doctor's physical or mental health. They also provide that it should be open to a FTP panel, in certain circumstances, to hold a public hearing in a health case. Such public hearings are likely to be unusual.

25.291 A FTP panel may, of course, engage in private deliberations (i.e. discussions about the decisions it has to make or about other issues relevant to a case) at any stage of a hearing.

The Hearing: Standard of Proof

25.292 The November 2004 Rules are silent on the standard of proof to be applied by FTP panels. The Guidance accompanying the November 2004 Rules states:

> **'Where it is making a finding on disputed facts, the panel must be sure of its decision.** (*That means that the criminal standard of proof is applied to findings of fact*.) **The issue of whether the practitioner's fitness to practise is impaired, and the imposition of a sanction, or warning, are matters of professional judgment.'**

25.293 The Guidance goes on to deal with decisions relating to sanction:

> **'The panel must be sure that any proposed action (whether to close a case with or without a warning, or to impose a sanction on the doctor's registration) is sufficient to protect patients and the public interest, failing which it must consider taking action against the practitioner's registration or imposing a more severe sanction, as appropriate.'**

25.294 Both IC and FTP panels may, where it would be just to do so, consider and determine together two or more allegations against the same doctor within the same category or the separate categories of impairment listed in section 35C(2)(a)–(e). They may also consider and determine together allegations against two or more doctors. The Guidance accompanying the November 2004 Rules states:

> **'Hearings will, therefore, be holistic, in that allegations will be brought forward based on the totality of the evidence obtained during the investigation stage (including, where appropriate, health and performance assessment reports) and may comprise a combination of allegations relating to a doctor's health, performance or conduct, or based on a caution, conviction or determination.'**

25.295 In a recent letter to the Inquiry, the GMC observed that it would not be possible to approach the issue of standard of proof, as in the past, on the basis that it was determined by the category of case being heard. The letter stated:

> **'... the GMC appreciates that there are practical issues to be resolved and is therefore in discussion regarding its approach to the standard of proof and the way in which hearings will operate in this respect.'**

25.296 Mr Scott told the Inquiry that hearings would not be labelled 'health', 'conduct', 'performance', 'conviction' or 'determination'. Instead, hearings will deal with allegations of various kinds, side by side. There will not be different processes according to the nature of the allegation made. Mr Scott gave the example of a performance case where a complaint had been made about a specific incident or incidents. He said that, if evidence could be adduced to support the complaint, then the subject matter of the complaint could be asserted as a fact and the criminal standard of proof would apply to the making of a decision as to the truth or otherwise of that fact. If, however, the evidence to support the complaint was not available, the subject matter of the complaint could be used merely as a 'trigger' to carry out a performance assessment and would not feature in the list of charges. The relevant evidence before the FTP panel would then be the assessment report and the criminal standard of proof would not apply.

Comment

25.297 The issue of what standard of proof should be applied in GMC proceedings is a thorny problem. The GMC has always maintained that, out of fairness to the doctor, the criminal standard of proof must be applied to findings of fact in conduct cases. In Chapter 21, I observed that it seems something of a paradox that the GMC should insist on the criminal standard of proof and yet allow findings of fact to be made on a bare majority decision. I suggested that the civil standard was more appropriate in proceedings which had the protection of patients and the public interest as their primary objectives. In the case of Sadler v General Medical Council[2], the Court observed that the appropriate standard of proof in a performance case was the civil standard. Under the new procedures, a FTP panel may have to decide issues of conduct, performance and possibly health during the same hearing. It would be quite a tall order for them to direct themselves properly as to the different standards of proof, especially without the guidance of a legally qualified chairman. In my view, the appropriate standard of proof within a protective jurisdiction is the civil standard. In proceedings affecting the welfare and safety of children, the civil standard of proof is applied, notwithstanding the facts that the allegation considered might also amount to a criminal offence and the consequence of an adverse finding might well be the loss of contact with a child. I shall recommend that the GMC adopts the civil standard of proof for all cases, except, perhaps, those allegations of misconduct which also amount to a serious criminal offence, for which cases the criminal standard of proof would arguably be appropriate.

The Hearing: Procedure

25.298 The procedure to be followed at a hearing of a FTP panel was set out in the 2003 draft Rules but has been extensively revised since. I do not propose to set out the procedure in detail. Its main elements, as they appear in the November 2004 Rules, can be summarised briefly.

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[2] [2003] 1 WLR 2259.

Evidence about the Facts

25.299 Following any preliminary legal arguments, the doctor will indicate whether s/he wishes to make any admissions. Where facts are in dispute, the Presenting Officer will open the case for the GMC and may adduce evidence and call witnesses in support of the case. As at present, witnesses will give evidence on oath or will affirm. They can be compelled to attend.

The Admission of Hearsay and Other Inadmissible Evidence

25.300 There is no significant change to the rule governing the admissibility of evidence. The November 2004 Rules provide that an IC panel or FTP panel may:

> **'... admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law'**.

That provision is subject to a proviso:

> **'Where evidence would not be admissible in criminal proceedings in England, the Committee or Panel shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable.'**

This provision is very similar to the equivalent rule under the old procedures. I hope that, in the future, FTP panels will be more ready to admit hearsay evidence than they have been in the past.

Vulnerable Witnesses

25.301 A welcome development is the rule providing for the treatment of vulnerable witnesses, including young people and witnesses who claim to have been the victim of a doctor's sexual misconduct. The rule enables an IC or FTP panel to use such measures as video links, pre-recorded evidence, interpreters or intermediaries, screens and the hearing of evidence in private to assist such witnesses. A doctor who is unrepresented will not be permitted to cross-examine a witness who claims to have been a victim of sexual misconduct by him/her without the written consent of the witness. Instead, the doctor (or, failing that, the GMC) must appoint a legally qualified person to cross-examine on his/her behalf. The FTP or IC panel must take into account the advice of the legal assessor and any representations from the parties in relation to the treatment of vulnerable witnesses.

Inquisitorial or Adversarial Proceedings

25.302 Historically, proceedings before the PCC panel were adversarial in nature. Recently, there has been some discussion about the possibility of adopting a more inquisitorial procedure, whereby it would be open to panellists to explore areas of evidence not covered by the parties' advocates.

25.303 In its 2001 Consultation Paper, the GMC said:

> **'There is a concern that PCC hearings are oppressive and upsetting, particularly to witnesses. Although a move to a more inquisitorial procedure would not negate the need for the evidence of witnesses to be thoroughly tested, it is arguable that a less adversarial approach would create a greater sense of an impartial investigation of the facts and achieve the same results, while causing less distress to those questioned. Any changes would have to safeguard the rights of doctors to defend themselves fully. The GMC's preferred direction is towards a more inquisitorial model, and it intends to commission work, drawing, where appropriate, on best practice elsewhere, to explore the possibility of developing an inquisitorial process for the PCC which would not compromise the doctor's right to a fair hearing.'**

25.304 The proposed move to a more inquisitorial process was supported by a large majority of respondents to the 2001 Consultation Paper, both medical and lay.

25.305 Following the consultation process, the GMC examined some examples of inquisitorial processes, but concluded that the existing style of PCC hearings should be retained. In coming to that conclusion, the GMC emphasised the extent to which members of the PCC were involved in questioning witnesses. Indeed, it suggested that the process before the GMC was not (as it appeared to have accepted in its 2001 Consultation Paper) purely adversarial, but was instead **'hybrid'**, in that it incorporated both adversarial and inquisitorial elements.

25.306 In fact, while FTP panellists are able to ask some questions, they are not encouraged to allow their questions to range too widely. The September 2004 draft Guidance for Panellists advises that **'the purpose of the Panel's questions is to seek clarification, not to cross-examine the doctor or witness'**. The intention seems to be that panellists should ask questions only to clarify issues that have already been raised. In my view, this is a pity. I have seen examples of cases before PCC panels in which the advocates on both sides had failed to explore an issue which was of real importance. An example was the case of Council for the Regulation of Healthcare Professionals v General Medical Council and Solanke[3], in which the doctor had admitted to the PCC having an improper relationship with a vulnerable patient and that he was, therefore, guilty of SPM. Neither counsel had sought to explore the circumstances in which the relationship had begun. This was plainly an important issue. The outcome of the case was the imposition of a sanction that appeared to the CRHP/CHRE, to be unduly lenient. It appealed to the High Court. The Judge held that, on the basis of the information available, the decision was at the lenient end of the spectrum but not unduly lenient. He pointed out, however, that the case had not been properly investigated and that no questions had been asked at the hearing about how the relationship had begun. This was, the Judge said, 'a serious failing'. Had it been regarded as acceptable for panellists to explore issues for themselves, this might have occurred in the case of Solanke and all the relevant facts might well have emerged.

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[3] [2004] EWHC 944 (Admin).

25.307 In my view, there should be a change of policy on this issue. I do not suggest that GMC proceedings should become purely inquisitorial. However, I do think that they should become more inquisitorial in that panellists should be encouraged to ask questions and to explore issues which they think are of relevance, even if it appears that the parties do not intend to do so. The objective of the hearing is, after all, to enable the panel to reach the right decision for the protection of patients and the public.

Submissions Made and Evidence Adduced by the Doctor

25.308 At the conclusion of the GMC's evidence, the doctor may submit to the FTP panel that the evidence which has been adduced is insufficient to enable the panel to find the facts proved, or to support a finding of impairment of fitness to practise. If such a submission of 'no case' is made, the FTP panel must consider and announce its decision whether to uphold the doctor's submissions. If no submission is made, or if a submission fails, the doctor may then open his/her case and may adduce evidence and call witnesses in support of it. The chairman of the FTP panel will then ask the specialist adviser(s), if any, to give any advice on the medical issues. The legal assessor may be invited to give advice on points of law.

The Panel's Findings of Fact

25.309 The FTP panel will then consider the evidence and announce its findings on the facts. The May 2004 draft Rules provided that, save in exceptional circumstances, a FTP panel should not be required to give reasons for its findings of fact. That provision did not appear in the July 2004 draft Rules, nor does it appear in the November 2004 Rules. It was not at first clear to me whether this change in the Rules meant that FTP panels would always give reasons or whether it merely indicated that the GMC no longer considered that the issue needed to be covered by the Rules. I hoped that the former was the case because it is important, in the interests of transparency, that the parties and the public understand why a FTP panel has decided as it has at all stages of the proceedings. However, the September 2004 draft Guidance for Panellists says that panels will not normally be required to give reasons for findings of fact unless it is necessary to do so. Examples given are when it is necessary to **'clarify the finding of fact'** or **'in other exceptional circumstances'**. I do not think this is at all satisfactory. It is important, as I have just said, that the parties and the public should understand why decisions have been reached. I do not suggest that elaborate explanations should be given. Nor should it be necessary for the panel to deal with every single disputed fact. However, panels ought to explain their findings on the crucial factual issues and it should be possible for this to be done in a few sentences. I can see that this would be easier for a legally qualified chairman than for one who is not.

Evidence and Findings on the Issue of Fitness to Practise

25.310 A FTP panel will have the power, under rule 17(4), before making a determination whether a doctor's fitness to practise is impaired, to direct a health or performance assessment. This is a welcome development and means that a FTP panel will be able to get a more

rounded picture of the doctor than at present. On receipt of the assessment report, the FTP panel may then proceed to consider and determine the allegation or may, under rule 17(5)(b), refer the allegation back to the Registrar for referral to the case examiners so that they can consider whether it would be appropriate for the doctor to be dealt with by way of voluntary undertakings.

25.311 This latter provision causes me some concern. It is obviously useful that a FTP panel should be able to obtain the assessment but it would be thoroughly unsatisfactory if, having received the assessment, the panel could avoid making findings of fact or a decision whether the doctor's fitness to practise is impaired. That appears to be the effect of the provision I have just mentioned. So, for example, in a case where a doctor has been convicted of offences of dishonesty in the context of drug addiction, there will be a referral to a FTP panel but the panel, on receiving a health assessment, might send the case back for voluntary undertakings without there being any finding of impaired fitness to practise. This really will not do. If the GMC is to regain the confidence of the public, it must be seen to be taking appropriate action. Once seized of a case, a FTP panel must reach a decision. It could still send the case for voluntary undertakings if it thought that that was appropriate after deciding that there was impairment of a degree justifying action on registration. However, in my view, the better course would be for the FTP panel to impose conditions itself and to have the same supervisory arrangements for conditions imposed by a FTP panel as for voluntary undertakings.

25.312 Apart from exercising its power to order a health or performance assessment, the FTP may also receive any further evidence and hear any further submissions from the parties as to whether, on the basis of any facts found proved, the doctor's fitness to practise is impaired.

25.313 The 2003 draft Rules specifically provided for FTP panels to receive evidence about a doctor's past history before making a finding in relation to impairment of his/her fitness to practise. The Guidance which accompanied the 2003 draft Rules stated that the Presenting Officer would be able to adduce evidence about previous warnings issued by the IC and findings by a FTP panel that the doctor's fitness to practise was impaired. This was at the stage after the FTP panel had made its findings of fact and before it made a decision as to the doctor's fitness to practise.

25.314 By contrast, there is no explicit provision in the November 2004 Rules which requires a FTP panel to take into account a doctor's FTP history. The Guidance which accompanies the November 2004 Rules is silent on this point, as is also the September 2004 draft Guidance for Panellists. This omission is puzzling as it surely cannot be intended that FTP panels should not consider this information. It may be that the GMC had concluded that there is no need to make provision for it in the Rules. There was such a provision in the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988, under the old procedures, and there is a provision in the November 2004 Rules governing the procedure of IC panels when considering warnings. Why is there no such provision for FTP panels? It might have been omitted by mistake, but then one would have expected to see reference to consideration of the doctor's past history in the September 2004 draft Guidance for Panellists. But it is

not there either. I think it should be spelled out exactly what previous history (if any) the FTP panel will look at and at what stage.

25.315 In Chapter 21, I mentioned my concern that PCC panels often took purely personal mitigation into account when deciding whether a case of SPM had been proved. I explained my view that such personal mitigation was quite irrelevant to the issues of SPM, but that PPC panels might have been misled by the decision of the Judicial Committee of the Privy Council in the case of Rao v General Medical Council[4], which was based upon a misunderstanding of what had been said in the case of Preiss v General Dental Council[5]. This problem should not arise under the new procedures because purely personal mitigation will be relevant to the issue of whether a doctor's fitness to practise is impaired. The whole picture will be relevant including past misconduct, past problems of health or performance and personal mitigation.

The Test to Be Applied

25.316 When it has received the further relevant evidence, the FTP panel will deliberate and will announce its findings on impairment of fitness to practise. It must give reasons for its decision. Rule 17(2)(k) of the November 2004 Rules requires a finding as to whether the doctor's fitness to practise is 'impaired'. The rule does not add the words 'to a degree justifying action on registration'. The rule correctly reflects the statutory test in section 35D of the 1983 Act. Inconsistently with that, the September 2004 draft Guidance for Panellists says that FTP panels will decide whether fitness to practise is impaired **'to a degree justifying action on registration'**. This kind of inconsistency is very confusing. The position is this. The first task of the FTP panel is to decide whether the doctor's fitness to practise is impaired. I have suggested a test that it should apply. If it finds that the doctor's fitness to practise is not impaired, the panel will usually take no further action although it may, under section 35D(3), give the doctor a warning as to his/her future conduct or performance. If the FTP panel decides that the doctor's fitness to practise is impaired, it should then go on to decide (under rule 17(2)(l)) what sanction to impose. It is at that stage that the panel must decide whether the impairment is such as to justify action on registration. Although the draft Guidance advises panellists that they may (in wholly exceptional circumstances) decide that fitness to practise is impaired and yet take no action, I find it hard to imagine circumstances in which that would be appropriate if the FTP panel found that the impairment of fitness to practise was of a degree justifying action on registration. What the FTP panel can do if it finds that the doctor's fitness to practise is impaired, but not to a degree such as to justify action on registration, is not entirely clear. I will return to this point very shortly.

The Hearing: Consideration of Sanctions or Other Action

25.317 If the FTP panel finds that the doctor's fitness to practise is impaired, it will then receive further evidence and will hear any further submissions from the parties about the appropriate sanction, if any, to be imposed. At any stage before making its decision as

[4] [2003] Lloyd's Rep Med 62.
[5] [2001] 1 WLR 1926.

to sanction or warning, the FTP panel may adjourn for further information or reports to be obtained in order to assist it in exercising its function. The Presenting Officer and the doctor's representative are expected to refer to the relevant part(s) of the GMC's Indicative Sanctions Guidance for Fitness to Practise Panels. The FTP panel chairman will again invite the specialist adviser(s), if any, and the legal assessor, to provide advice on the medical and legal issues.

25.318 The FTP panel will then consider and announce its decision whether to impose a sanction or a warning or to **'take into account'** undertakings that have been offered. It must give reasons for its decision. Decisions of the FTP panel are taken by a simple majority. No abstentions are permitted and there is no casting vote. Where the votes are equal, the FTP panel must decide the issue under consideration in the doctor's favour. The only exceptions to this latter rule occur when a FTP panel is considering a submission of 'no case' or where a FTP panel is considering an application to restore a doctor's name to the register, in which case the issue must be resolved against the doctor where the votes are equal.

Sanctions

25.319 Section 35D(2) of the 1983 Act provides that, where a FTP panel finds that a person's fitness to practise is impaired, it may if it thinks fit:

> **'(a) except in a health case, direct that the person's name shall be erased from the register;**
>
> **(b) direct that his registration in the register shall be suspended ... during such period not exceeding twelve months as may be specified in the direction; or**
>
> **(c) direct that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Panel think fit to impose for the protection of members of the public or in his interests'**.

25.320 These sanctions are the same as those that were available to the PCC. In addition, the PCC had a specific additional power to admonish a doctor in a case where it had found the doctor guilty of SPM but had decided to take no action. After 1999, the term 'reprimand' was used instead of the rather old-fashioned 'admonishment'. A significant change from the past is that, whereas erasure was not available as a sanction to the CPP in a performance case (although indefinite suspension was, in certain circumstances), it will be possible for a FTP panel to direct that the name of a doctor should be erased from the register if it finds his/her fitness to practise impaired by reason of deficient professional performance. The power to impose a sanction is discretionary and it is therefore open to a FTP panel to take no action even after a finding that a doctor's fitness to practise is impaired to a degree justifying action on registration. As I have said, I find it difficult to imagine circumstances in which that would be appropriate.

25.321 A doctor is entitled to appeal to the High Court against a decision of a FTP panel. The FTP panel's determination will not usually take effect until the period for an appeal to be lodged (28 days) expires, or until the appeal itself has been determined. Where a FTP panel considers it necessary for the protection of members of the public, or in the interests of the public or the doctor, it may impose an order of suspension or conditions that will take effect immediately. The power to impose immediate conditions on a doctor's registration is new and welcome.

Warnings

25.322 As I have noted earlier, section 35D(3) provides that, where a FTP panel finds that the doctor's fitness to practise is not impaired, it may nevertheless issue a warning about his/her future conduct or performance. I can understand why this provision has been inserted. It would be appropriate in a case in which the doctor had done something wrong, possibly making a prescribing error or missing a diagnosis (so that his/her fitness to practise had at the relevant time been impaired), but had taken immediate steps to rectify his/her shortcomings so that, by the time the case came before the FTP panel, his/her fitness to practise was no longer impaired. The September 2004 draft Guidance for Panellists suggests that a warning may be given where there is significant cause for concern after a performance assessment. I have already expressed my reservations about the usefulness of that procedure, if there is to be no form of follow-up.

25.323 Strangely, section 35D does not give the FTP panel the power to issue a warning where it has found an impairment. This *lacuna* must surely be unintentional and must be remedied. It is absurd that the FTP panel may find that the doctor's fitness to practise is impaired, although not to a degree justifying action on registration, but that it could not then issue a warning. I think that the GMC has become confused because it forgets that the statutory test is 'impairment of fitness to practise' not 'impairment to a degree justifying action on registration'. For the avoidance of doubt, I repeat that, in my view the scheme should be as follows:

- if the panel finds no impairment it will either take no action or may give a warning under section 35D(3)
- if the panel finds impairment falling short of that justifying action on registration, it should be able to issue a warning and may exceptionally take no action
- if the panel finds an impairment justifying action on registration, it should impose one of the three sanctions in the statute.

Written Undertakings

25.324 Rule 17(2)(m) of the July 2004 draft Rules introduced a new provision which has been reproduced in the November 2004 Rules. A FTP panel may **'take into account'** any written undertakings (including undertakings relating to limitations on his/her practice) entered into by the doctor which the FTP panel considers to be sufficient to protect patients and the public interest. The doctor must expressly agree that the undertakings (save any relating

exclusively to his/her health) should be disclosed to his/her employer or PCO, to any prospective employer or PCO and to any enquirer.

25.325 It is not quite clear to me what is meant by **'take into account'**. Does it mean that, when considering what sanction to impose after a finding of impairment of fitness to practise has been made, the FTP panel may decide that the undertakings offered would provide an adequate degree of protection and that no other action is necessary? If so, that would be reasonable, provided that there were adequate supervision of compliance with the conditions and that a breach of them were to be regarded as every bit as seriously as a breach of conditions imposed by the FTP panel itself. At present, there is no provision in the 1983 Act or the November 2004 Rules for the supervision of a doctor who is subject to such undertakings or for cases where undertakings have been given to be brought back to the FTP panel for routine review or for reconsideration in the event of a breach of undertaking. Nor does it appear that the GMC would have any 'teeth' with which to deal with a breach. No doubt those matters could be rectified and, if this procedure is to be used, they must be. However, I cannot see any real reason why a FTP panel should ever need to **'take into account'** undertakings when considering sanction. If the FTP panel has heard the evidence, it can impose appropriate conditions itself and the existing Rules make provision for review and for action in the event of any breach.

25.326 It is not clear from the Rules whether this provision is intended to have the limited application that I have just described. The positioning of the relevant provision within the November 2004 Rules and the contents of the September 2004 draft Guidance for Panellists suggests that this will be the case. However, the possibility occurs to me that it might be intended to **'take into account'** or accept undertakings from a doctor at an earlier stage in the proceedings. The provision is wide enough to permit that. If that were done, the FTP panel might never reach the stage of making findings of fact or deciding whether there was an impairment of fitness to practise. That would not be at all satisfactory. I have already explained why essential findings should not be 'fudged'. There must be a clear basis on which the GMC acts. Otherwise there can be no proper protection of the public interest.

Publication of Panel Decisions

25.327 A decision reached by a FTP panel, together with reasons, will be notified to the doctor, to his/her employer or PCO and to any person or body which brought the allegation to the GMC's attention. In addition, it will be published on the GMC's website. The only exception is that confidential information about a doctor's health will not be made public.

Review Hearings

25.328 The Guidance which accompanied the July 2004 draft Rules stated that an order for suspension or for the imposition of conditions would be reviewed by a FTP panel prior to the end of the period for which the suspension or conditions were imposed. The Guidance accompanying the November 2004 Rules states that such an order will **'generally'** be reviewed. In my view, there should have to be quite exceptional reasons for not holding a review hearing. There is no provision in the Rules for the date of a review hearing to be

fixed at the original FTP panel hearing, as was the practice under the old procedures in a health or performance case. Review hearings are extremely important, as they are the 'teeth' behind the sanctions other than erasure. If a doctor thinks that a period of suspension or conditional registration will simply expire and that s/he will automatically be allowed to return to unrestricted practice, there will be cases in which the remediation objective behind the imposition of suspension or conditions will not be achieved and patients will be put at risk.

The 2003 Proposals

25.329 The 2003 draft Rules provided for the appointment of a case examiner to assist the FTP panel in carrying out its investigations and with preparing evidence for a review hearing. The appointed case examiner was to be responsible, *inter alia*, for procuring evidence and for inviting the doctor to undergo a health assessment or directing a performance assessment as appropriate.

The 2004 Position

25.330 These arrangements were changed by the May 2004 draft Rules (reproduced in the November 2004 Rules), with the result that all these functions are now to be undertaken by the GMC staff, not by case examiners. I assume that this change was made as part of the attempt by the GMC to mitigate the effect of the significant increase to the workload of case examiners caused by the introduction, in the May 2004 draft Rules, of the double-handling of cases by case examiners. In my view, the 2003 proposals were better and should be reinstated.

25.331 It seems to me that what is required is that someone should be responsible for keeping a watchful eye on the progress of any doctor subject to conditions during the operative period. When examining the old procedures, I came across cases in which conditions had been imposed, including supervised practice and a package of remedial measures, but in which nothing at all had happened for several months. Someone in the GMC should be keeping watch to ensure that the doctor adheres to the conditions imposed and, where appropriate, should request regular progress reports. When the end of the period of suspension or conditional registration approaches and preparations are to be made for a review hearing, it seems to me that, in virtually every case, there should be some sort of independent assessment of those aspects of the doctor's performance or health that had given rise to the original finding of impairment of fitness to practise. In the past, the GMC has often released a doctor from conditions on the basis of a report from someone involved in his/her remediation. I am by no means convinced of the adequacy of some of these reports as a basis for ending supervision. Those who have been involved in facilitating a doctor's remediation are not always best placed to assess its results. We all like to think that we have done a good job and there is a grave danger that a report from someone who has been involved will present an unduly sanguine view of the doctor's progress. In any event, such a person is unlikely to have undertaken any objective, measurable assessment of the doctor's performance or competence. In my view, there should be something more patently independent and objective.

Early Review Hearings

25.332 There is also provision for an 'early review hearing'. The 2003 draft Rules provided that such a hearing could be held on the application of the doctor, if a case examiner so directed. In addition, the 2003 draft Rules provided that a case examiner should be able to direct an early review hearing where information was received that suggested that such a hearing was **'necessary'** or **'desirable'**. The May 2004 draft Rules gave the power to direct an early hearing to the Registrar (i.e. the GMC staff) rather than to a case examiner. A direction for an early review hearing was to be made when the Registrar was of the opinion that it was **'desirable'** to do so. This remains the case under the November 2004 Rules. The right of the doctor to request an early review was retained. However, the July 2004 draft Rules omitted the reference to an application by the doctor for an early review and it was not restored in the November 2004 Rules.

25.333 The provision that there should be an early review when the Registrar (in practice a member of staff) thinks it **'desirable'** is very vague. There is no requirement that there must be an early review in the event of a breach of a condition or undertaking. Also, it appears that the whole system will be reactive; it will depend upon someone reporting to the GMC that a problem has arisen. It does not appear that anyone in the GMC will be 'keeping watch'. There is no provision even for a supervisor to submit a regular report.

The Procedure on a Review Hearing

25.334 The doctor must be given at least 28 days' notice of a review hearing and must be provided with certain specified information, including any new evidence. The doctor will be required to indicate whether s/he wishes to attend the hearing. If s/he does not attend, s/he will have an opportunity to make written representations.

25.335 At the review hearing, the Presenting Officer representing the GMC will inform the FTP panel of the background to the case and of the sanction previously imposed. He or she will direct the FTP panel's attention to any relevant evidence, including transcripts of previous hearings. The 2003 draft Rules provided that both the GMC and the doctor should be permitted to call or produce evidence. However, the May 2004 draft Rules would have permitted only the doctor to adduce evidence and call witnesses, making the hearing a one-sided process. The July 2004 draft Rules contained a provision permitting the GMC to adduce evidence also and to call witnesses in relation to the doctor's fitness to practise. The November 2004 Rules also permit evidence to be called by the GMC about any failure on the part of the doctor to comply with a condition previously imposed upon his/her registration. That is most welcome. After the GMC's evidence, the doctor may present his/her case, may adduce evidence and call witnesses in support of it. The FTP panel will then receive further evidence and hear submissions as to whether the doctor's fitness to practise is impaired or whether s/he has failed to comply with any condition imposed on his/her registration.

25.336 The FTP panel must then consider and announce its finding on the question of the doctor's fitness to practise and in relation to any alleged breaches of conditions. This procedure is good in principle although, as I have said, in my view, there ought to be some up-to-date independent objective evidence about the doctor's fitness to practise.

25.337 The FTP panel may then receive further evidence and hear any further submissions from the parties about its disposition of the case and must then consider and announce its decision as to the appropriate direction. It will be open to the FTP panel at this point to **'take into account'** any written undertakings entered into by the doctor in the same circumstances as I have described previously.

25.338 The various courses of action open to a FTP panel at this point are set out in section 35D of the 1983 Act and vary according to the direction that was originally made by the panel. Where a FTP panel has given a direction that a doctor's registration should be suspended, it is open to the FTP panel at a review hearing to direct that the period of suspension should be extended for a specified period not exceeding 12 months at a time. It is also open to the FTP panel, except in a health case, to direct erasure of the doctor's name from the register. The FTP panel may also direct that the doctor's registration should, from the expiry of the current period of suspension, be conditional upon compliance with specified requirements for a period not exceeding three years.

25.339 In Chapter 21, I discussed the problems that could be created by a period of suspension. If the suspension had been ordered as a 'sharp rap on the knuckles' for a doctor who had been guilty of some form of misconduct which did not affect his/her clinical practice, it might not have been inappropriate for the doctor to be permitted automatically to resume practice when the period of suspension expired. However, if suspension were imposed on account of poor performance, ill health or a form of misconduct which did affect clinical practice, the effect of suspension might be that the doctor was even more unfit to practise at the end of the period than at the beginning. He or she would have been 'out of practice' in both senses of the expression. Sometimes, the panel imposing the suspension would advise the doctor as to what remedial steps s/he should take while suspended. But it was thought, rightly in my view, that no conditions could lawfully be imposed during a period of suspension so supervision was not appropriate.

25.340 Under the new procedures, it seems unlikely that suspension will be ordered in any case unless there is quite a serious degree of impairment of fitness to practise. It is not possible to impose conditions during the period of suspension, although FTP panels might sensibly advise doctors as to the remediation they think it appropriate that they should undertake while suspended. It seems to me that no doctor who has been suspended should ever be allowed to resume practice without undergoing some form of assessment. In my view, it is not sufficient to impose conditions at the expiration of the period of suspension. Conditions will almost certainly be required, but they should be imposed after the doctor has successfully passed an assessment of basic competence.

25.341 Where the original direction was for conditional registration, the FTP panel at a review hearing may direct erasure (except in a health case), direct that the doctor's registration should be suspended, for a maximum period of 12 months, or direct that the period of conditional registration should be extended for a period of not more than three years. It is also open to the FTP panel to revoke its original direction or to revoke or vary any of the conditions imposed by the direction for the remainder of the current period of conditional registration. Where a doctor has failed to comply with a condition on registration, a FTP panel may, except in a health case, only direct erasure of the doctor's name from the register or direct that the doctor's registration should be suspended.

Comment

25.342 I have already mentioned some of my concerns about what might be described as the 'business end' of the new FTP procedures. The mere imposition of conditions or suspension is not enough to protect the public from a doctor whose fitness to practise is impaired. There must be proper supervision and adequate assessment of the doctor before s/he is allowed to return to unrestricted practice. I do not think it is satisfactory for a long period of conditions to be imposed, as this means that the doctor can disappear from sight and practise under very little supervision. The GMC might think that a doctor will be supervised locally by his/her PCO. However, in my view, the GMC should take responsibility. Also, a relatively early date for a review hearing before a FTP panel might well have the effect of focussing the doctor's mind on his/her remediation. In my view, periods of conditional registration should not usually exceed 12 months initially. A renewed period may well be necessary but the shorter initial period will at least mean that the doctor is brought back for review within a reasonable time.

25.343 I have already expressed my concern also that there is no provision in the Rules for the regular monitoring or surveillance of a doctor who is subject to a direction for conditional registration imposed by a FTP panel. In other words, the doctor is less well supervised than s/he would have been under the old voluntary health or performance procedures. This is a serious gap and means that conditions imposed by a FTP panel may well be significantly less onerous than for a doctor in voluntary procedures. (Of course, I recognise that the new arrangements for voluntary undertakings in cases with a health or performance element may be rather more lax in future, when they will be under the control of staff rather than the health screeners and performance case co-ordinators who were able to bring expertise and continuity to their work. That remains to be seen.) However, there seems to be no sense in devising a system which is manifestly less stringent in cases where conditions are imposed by a FTP panel than when undertakings are entered into voluntarily. In my view, a professional supervisor should be appointed in every case where a doctor is practising under conditions, and that professional supervisor should provide regular feedback to the GMC. There should be a medical supervisor in all health cases and s/he should be expected to operate to the standards that were required under the old voluntary health procedures. Also, in my view, some form of independent assessment must be made before conditions are lifted.

Applications to Restore a Doctor's Registration

25.344 The 2003 draft Rules set out the procedure to be adopted when a doctor whose name has been erased from the register applies for restoration. They provided for a case examiner to be appointed to consider and prepare the evidence to be placed before the FTP panel at a restoration hearing. He or she was to have the same powers to procure expert and other evidence as in relation to a review hearing. These arrangements were changed by the May 2004 draft Rules and the changed regime is reflected in the November 2004 Rules. The staff – and not case examiners – will carry out the functions that were previously to be carried out by the case examiners. I think that that is a retrograde step. I can see no reason of principle why case examiners should not be required to undertake this work;

they are manifestly better qualified to do so than GMC staff. I can only conclude that the reason for the change was to reduce the workload of case examiners.

25.345 The November 2004 Rules contain no requirement that a performance or health assessment should be carried out automatically in the case of every application to restore. The staff may direct an assessment of performance or health; it is open also to the FTP panel which hears the application to direct an assessment before making its decision. In my view, it should be mandatory for a doctor to undergo an assessment of every aspect of his/her fitness to practise before his/her application to restore is heard. Since the amendment to the 1983 Act effected in 2000, the doctor will inevitably have been off the register and away from clinical practice for an appreciable time – five years if the erasure was not voluntary.

25.346 The procedure at a restoration hearing is similar to that at a review hearing, save that the decision to be taken by the FTP panel is whether to grant or refuse the application to restore. The FTP panel must give reasons for its decision. In an appropriate case, it may make a direction suspending indefinitely the applicant's right to make further applications for restoration. It is not open to the FTP panel to restore the doctor to the register subject to conditions. I understand that the GMC believes that FTP panels might restore applicants too readily if the option to restore with conditions is available. It also takes the view that, if there are doubts about a doctor's fitness to practise, the decision should be to refuse restoration. I understand that point of view. But the time must come where a panel thinks it appropriate to restore but where a period of supervision would be a wise safeguard. I recommend that every doctor restored to the register after erasure should have a mentor, who undertakes to monitor his/her progress and to report to the GMC.

Appeals

25.347 Decisions of FTP panels will be subject to appeal by a doctor and to judicial review on the application of a complainant. In addition, the CRHP/CHRE will be able to refer a decision of a FTP panel to the High Court in certain circumstances. The GMC has pointed out that it has no power to appeal decisions made by FTP panels. The GMC says that it wishes to have the ability to question those decisions that do not appear adequately to protect the public interest. In a briefing paper for the May 2004 Council meeting, it was pointed out that the GMC could invite the CRHP/CHRE to mount an appeal on its behalf; however, it was suggested that that was not a satisfactory alternative to being able to act itself.

25.348 As a consequence, the GMC agreed at its May 2004 meeting that, subject to further work on mechanisms and to consultation, it should request further legislation to enable the GMC to appeal to the High Court against decisions of FTP panels which it considered unduly lenient, either as to sanction or as to whether the doctor's fitness to practise was impaired on the facts found. In my view, such a power would be inappropriate and is in any event quite unnecessary. It would be inappropriate because the GMC continues to exercise a very close degree of control over FTP panels. It is unnecessary because the CRHP/CHRE has the power and the resources to mount an appeal. If the GMC is concerned about a decision being unduly lenient, it can invite the CRHP/CHRE to take action; indeed, it has already adopted this course in a recent case. The GMC is under a

duty to co-operate with the CRHP/CHRE and this seems to me to be an obvious area for such co-operation.

Conclusions

25.349 In the course of this long Chapter, I have expressed my views about the GMC's proposals for its new FTP procedures. It is clear that, in some areas, the new procedures will be a significant improvement on the old and, in other areas, the reverse appears to me to be the case. I do not propose, at this stage, to repeat the detailed observations that I have made as I have gone along. Instead, I want to stand back and examine the new procedures in the round.

25.350 In Chapter 15, I reported at some length the opening submissions to the Inquiry of Mr Roger Henderson QC on the GMC's behalf. I shall not repeat them here. Their gist was an acceptance that there was much that had been unsatisfactory under the old procedures. However, I was urged to accept, those were the 'bad old days' and it would all be different in the future. This was also the message to the Inquiry from the GMC witnesses, in particular from the President and the Chief Executive. I have no hesitation in accepting the sincerity of their expressions of intention. However, I have grave reservations about the willingness and ability of the GMC as presently constituted to change its ways.

25.351 I regret to say that my overall reaction to the way in which the new procedures have been developed is one of disappointment. Although, in the early days, at the time of the 2001 Consultation Paper, there was every indication that the GMC had a vision of what it wanted to achieve, that vision has been lost. I do not believe that that vision, or the purpose or principles that underpinned it, have been translated into the new procedures.

25.352 The GMC knows what the fundamental purpose of its FTP procedures is or should be. It was clearly set out in the 2001 Consultation Paper. The fundamental purpose was said to be to promote and safeguard the public interest, which involved individual patient protection, the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct. In my view, if that fundamental purpose is to be met, there are some basic principles that should be applied; for example, subject to the requirements of medical confidentiality, everything that the GMC does must be capable of scrutiny; it must be transparent. The work that the GMC does must be thorough, careful and of high quality. That means that every aspect of the FTP procedures must be properly resourced. Each process must be undertaken by persons who are suitably qualified and properly trained to carry it out. In the interests of fairness and of the proper maintenance of standards, procedures must be followed and decisions made in a consistent, transparent manner. Those are the broad principles that should have been followed in developing the GMC's approach to its new procedures. They should not have been forgotten right to the end.

25.353 The criteria for evaluating the proposals that were enunciated in the 2001 Consultation Paper reflect those principles but they have not been met. By way of illustration, one such criterion was compliance with the Human Rights Act 1998, and the GMC said that it was

'in no doubt' that it was necessary, in order to demonstrate that its procedures were fair, to separate the investigation and adjudication functions. Not only would this ensure compliance with the Human Rights Act 1998, but it would foster public confidence and it would satisfy those doctors who felt that it was unfair that they should be prosecuted and judged by the same body. The GMC talked about this idea and then decided – in effect – to abandon it. Members could not bring themselves to relinquish part of the process. It seems that their justification for this was that they believed that no one else could undertake either of the functions as well as they could. And yet, this was a body that had been the subject of severe public criticism on many grounds and which had embarked on reform, apparently because it had recognised the force of that criticism.

25.354 There is one issue of importance that was present in the minds of GMC members at an early stage and from which they have not resiled. That was the need to abolish the separate procedures for conduct, health and performance and to create a unified set of procedures for all types of case. That they have done and I do not think that anyone doubts that this was the right thing to do. The appropriate legislative changes went through in 2002. Since then, there has been no real sign of an overall plan carried through to fruition. There was the publication of the 2003 draft Rules, which contained some improvements on the old procedures and the retention or introduction of many unsatisfactory features. Since then, the GMC has responded to criticism from a variety of quarters, including this Inquiry. It has made some improvements. Many of the criticisms related to matters that the GMC might have been expected to have seen for itself, if it had formulated an overall vision of how it wanted its new procedures to operate. For example, it is amazing to me that the GMC should have resiled from its commitment, under the old procedures, to the involvement of lay persons in the preliminary processes for sifting complaints.

25.355 Such improvements as have come about since 2003 have been made in a piecemeal fashion and in response to criticism. But, unfortunately, not all the changes that have been made since the 2003 draft Rules have been for the better. Some provisions of the 2003 draft Rules have been changed for the worse. I have in mind in particular the changes to the role of the case examiners. In 2003, it was intended that they should fulfil a variety of functions, mainly during the investigation stage, but also including involvement in the supervision of doctors subject to voluntary undertakings and in the preparation of the cases of doctors subject to conditions, suspension and erasure who were coming up for a review or restoration hearing before a FTP panel. I am unaware of any criticism of the proposals that case examiners should fulfil those functions; indeed, I personally thought them satisfactory. Many of these functions have now been taken away from case examiners and have been given to members of staff who are not well qualified to carry them out. As I have said earlier in this Chapter, I cannot think of any reason of principle for those changes and am driven to the conclusion that they have been made for reasons of expediency. Another example of a change for the worse is the new provision for the cancellation of referrals to a FTP panel; the new arrangements are open to abuse and are not even remotely transparent. A third example is the arrangements for the issue of letters of advice. The lack of any clear criteria for their issue was identified as a defect under the old procedures. Yet, after an initial proposed improvement, the informal arrangements proposed have all the defects of the previous system.

25.356 One particular concern that I must mention is the lack of transparency in the way in which the new procedures have been developed. The draft Rules have been changed from time to time and new guidance has been issued to accompany new sets of Rules. There is, of course, nothing wrong with that. It is understandable that the GMC's thinking has developed over time and as a result of consultation. Yet, there has been very little public discussion at the GMC about the thinking behind the changes; nor are the reasons apparent from briefing papers prepared for the use of members at Council meetings. I have no doubt that the changing proposals have been fully discussed by the Fitness to Practise Committee and I accept that it is entirely proper that it should meet in private. However, it must have been very difficult for doctors, medical defence organisations, health administrators and the public (as it has been for the Inquiry), to trace the development of the procedures and to understand what has been decided and why. Indeed, even now that the new procedures are in operation, it is still difficult to find out exactly how they are going to operate. It must be apparent from this Chapter that it has not been easy for the Inquiry to piece the picture together. In my view, there is an urgent need for a handbook containing all the Rules, all the guidance currently in operation and any standards, criteria and thresholds to be applied when making decisions. The handbook should also give a clear and complete account of what can happen at each stage of the procedures. Moreover, the GMC must ensure that the guidance it issues is in conformity with the Rules and the underlying provisions of the 1983 Act. The handbook should be readily available and should be accessible on the GMC website.

25.357 The result of all the changes to the draft Rules is that the new procedures are much like a curate's egg: they are good in parts and not good in others. I have made a lot of suggestions about alterations that would, in my view, be for the better. I make them in a constructive spirit. I hope that some – if not all – of them will be adopted. But the process of change has been tortuous and piecemeal. It is discouraging, as it indicates to me that, even now, at the start of the new era, there is no real commitment to the underlying principles of good regulation. In short, I am not convinced that the leopard has changed its spots or ever will.