RESPONSE TO GMC CONSULTATION ON CONSENSUAL DISPOSAL & GUIDANCE TO THE FITNESS TO PRACTISE RULES

1. Consensual Disposal

1.1 What is and is not appropriate for 'consensual disposal'

Whilst we agree with the principle of inviting undertakings at an early stage without proceeding to a Fitness to Practise panel in appropriate cases, we think that this option should be used with extreme caution. We believe that sub-section (5) of the draft amended rule 10 needs to be amended so that cases where there is "*realistic **possibility**"* that if the case were referred to a fitness to practise panel the GMC might take "*further action"* on the registration of the doctor, are not dealt with under consensual disposal. There is a danger that with the current draft rule, cases will be dealt with more leniently than they should be because of assumptions made, without a full investigation and consideration of the issues, of what a fitness to practise panel would conclude. The rule also needs to take account of the fact that a fitness to practise panel might take stronger action on a doctor's registration, short of erasure from the register, and that if there is a realistic possibility of this, the case is not appropriate for consensual disposal. The example given in the guidance of "a single clinical incident" being a circumstance where consensual disposal is likely to be appropriate should be re-drafted. It depends on the nature of the single clinical incident as to whether consideration by a fitness to practise panel would be more appropriate.

1.2 Comments of the maker of the allegation / report

Whilst the draft guidance says that case examiners should consider any comments made by the maker of the allegation in deciding whether to deal with the case through consensual disposal, this should be made part of the actual rules. The maker of the allegation should be advised of the possibility of the case being concluded in this way, including details of the undertakings that are being required of the doctor, and be invited to comment *before* the doctor is invited to have the case concluded in this way. The maker of the allegation should be entitled to receive a written response from the case examiners concerning their comments and justification as to the decision made.

In AvMA's experience, it is unrealistic to assume that the average lay patient / member of the public who has made an allegation will be in a position to make "compelling arguments" to the case examiners concerning the best way of dealing with the case or adequacy of the undertakings, without specialist help. This highlights an issue which AvMA has consistently brought to the GMC's and the Department of Health's attention – that there is a need for a specialist independent advice & support service for people considering bringing or bringing allegations to the GMC and other regulators. No such service is currently funded, even though charities such as AvMA and Witness do a limited amount of this work using their own modest charitable resources. We would like to know what the GMC is doing to make the case for a funded support service, or whether this is something the GMC would consider contributing to itself.

1.3 Voluntary Erasure

We would like to be assured that voluntary erasure / removal from the register is not an option for a doctor who is the subject of an allegation which has been made to the GMC where an investigation has not been concluded by the GMC.

1.4 Review of Procedure

We would like to see an independent review of the operation of consensual disposal procedures after a year of operation and would be happy to contribute to such a review.

2. Fitness to Practise Rules

2.1 Terminology

We recommend that the GMC and other regulators of health professionals work together to become consistent in the way they describe their roles. We recommend that the terminology of "complaints" being made about health professionals to the regulators is dropped. The regulators are not complaints bodies, and the terminology is confusing for members of the public. It encourages people to bring some complaints about doctors to the GMC rather than to their employers / practice where they would be more appropriately dealt with. The terminology is also inappropriate in that the so-called "complainant", if their allegation is investigated by the GMC, becomes a "witness" as opposed to remaining in control of their complaint, which they would be in a genuine complaints process. The term 'allegation' about a doctor's fitness to practise is more accurate. However, both 'complaint' and 'allegation' have pejorative connotations, when in fact members of the public are being good citizens and doing a public service in bringing concerns about safety / fitness to practise of health professionals to regulators' attention. We therefore favour 'reporting concerns' about health professionals' fitness to practise.

2.2 Complaints about the GMC

We believe that the fitness to practise rules should include procedures for advising people who have reported concerns about a doctor's fitness to practise know about how to complain about the way that the GMC has dealt with their reported concerns. Information about this procedure should be made available in correspondence to the reporters of concerns. Currently, people dissatisfied with the fitness to practise process conducted by the GMC feel they are left with nowhere to go apart from judicial review, which is not a realistic prospect for most people. The GMC is also failing to avail itself of useful feedback and information on the quality of its operation which a well promoted complaints procedure would bring. There should also be a well publicised complaints procedure made accessible to the public covering the GMC as a whole, as with any public body.

2.3 Disclosure of full doctors' comments on allegations / reports

We would like to see the rules and guidance amended so that there is a guarantee that the person who has reported concerns about a doctor is sent all information provided by the doctor in response to the report / allegation made, and invited to comment. It brings the GMC's practice into disrepute not to ensure this happens. It gives the impression of a lack of transparency in the procedures and creates the risk that decisions will be made on the basis of information provided by the doctor which may have been contradicted / disproved by the reporter of the concerns had they been given the opportunity to do so.

2.4 "Stream one" and "Stream two" cases

We are concerned about the potential for what the guidance calls "stream two" cases being inappropriately dealt with. This is supposed to apply to "complaints that could justify action by the GMC if part of a wider pattern of concern but do not do so by themselves". We are concerned that the assumption at an early stage by GMC staff, without the benefit of further information or investigation, that a report / allegation would not in itself lead to action by the GMC if proven may not be a reasonable assumption to make. This is particularly so if, as we believe should be the case, the potential "action" includes letters of advice or the issuing of warnings. We believe there is a real danger of actions such as these which may be highly appropriate ways of ensuring that fitness to practise is not impaired are not taken when they should be if cases are referred to employers in this way. We do not think that it is appropriate or feasible for the GMC to delegate its responsibilities to employers in this way. Employers are not necessarily equipped to make judgements about a doctor's fitness to practise or compliance with *Good Medical Practice* and their complaints procedures are not designed to deal with such issues. We propose that the test for whether a reported concern should be dealt with by the GMC as a 'stream one' case should be:

"If proven, would there be a realistic possibility of the allegation leading to any action by the GMC, including a letter of advice or warning?"

We believe that a departure from *Good Medical Practice* should warrant at the least, a letter of advice or warning.

We recommend that there is an independent review of the operation of the fitness to practice rules and guidance, particularly in relation to 'stream two' cases. AvMA would be happy to assist with such a review.

2.5 Advice and Support for potential and actual reporters of concerns / witnesses

Paragraph 79 of the guidance refers to 'any reasonably practical measures will be taken to enable and assist a witness defined as vulnerable under the Rules'. We would like to see specialist advocacy support provided for witnesses who have alleged abuse by a doctor. A suitable organisation to provide such a service would be Witness. Such a provision appears to have been allowed for by the definition of vulnerable witnesses in the Rules. However, we would recommend that the GMC seeks the support of Government and / or takes steps itself to fund an advice and support service for any member of the public considering reporting or reporting concerns about a doctor to the GMC. Anyone responding to this consultation will have been reminded or made aware of how daunting and complex the procedures are for someone who is reporting their concerns. An average person would find it difficult to articulate their concerns and evidence in a way most likely to enable the GMC to assess them and make an appropriate decision and the prospect of acting as a witness in fitness to practise procedures is daunting for anyone. Our perception is that many potential reports of doctors with questionable fitness to practise are not made because of how daunting the prospect of filing a report and what follows is. Also, because of the lack of access to appropriate advice, many people take their concerns to the wrong place or do not report them at all. We believe that there needs to be a national (UK) helpline which can support and advise people who have concerns about their health care or health professionals, and a specialist advice and support service for people who wish to report concerns to a health professional regulator. Together these services would achieve the main goals of the 'single portal' for complainants recommended in the Shipman Inquiry report, and fill the gap in availability of support for people taking their concerns to the regulators. We believe that these services should be:

- independent of the health regulators themselves
- provided across the whole of the UK
- provided by organisations with appropriate experience and expertise in medico-legal, complaints and regulation matters

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