Response to the General Medical Council Consultation: “Reviewing how we deal with concerns about doctors: A public consultation on changes to our sanctions guidance and on the role of apologies and warnings”

Section 1: changes to our sanctions guidance

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<td>The GMC must define what it means by public confidence and how it judges public confidence. Unless defined, it is whatever one thinks it is and hence it is self-fulfilling. Our concern is that in reality it means ‘what do the newspapers think?’ - so the GMC is at risk of determining sanctions not on the basis of fairness, equity and the nature of the offence but based on the test of what the tabloid newspapers might think. Furthermore if this is the case the GMC is at risk of being biased against non-UK doctors who transgress - as tabloids appear to be more &quot;outraged&quot; by the failings of foreign medical graduates. The GMC needs to either test what public opinion is or ignore this issue. In the criminal courts judges do take public opinion into account when sentencing. But this is researched and is open to legal challenge. The current indicative sanctions guidance requires proportionality 'weighing the interests of the public with those of the practitioner' (paragraph 21). All sanctions have a damaging effect on the practitioner and it is highly unlikely that panels give weight to that if there is a real question of public safety/protection of patients. The whole issue hinges on judgments about seriousness, persistence and public confidence. The case examples are plausible but extreme and should not be used to justify allowing the principle of punishing doctors to placate the public/media. It seems therefore that these proposed change are intended to enable the rights of the doctor to be disregarded if sanctions are</td>
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imposed solely to maintain public confidence. This is at variance with the DH consultation on draft statutory instruments that shows fairness and justice as the over-riding consideration.

**Why is the GMC so concerned with the current very low numbers of exceptional cases?**

There are weighty issues facing medicine, involving many more doctors and as such many more patients, such as doctors’ mental health, and the need post-Francis to instil a culture of openness and compassion.

Finding additional regulatory sticks with which to ‘beat’ doctors who should more properly be dealt with via the criminal justice system seems a very skewed sense of priority.

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<td>1</td>
<td>Dr Manchester physically assaulted a patient. If erased/suspended he will lose his job and be evicted from his home</td>
<td>In this case it may well be prudent to <strong>not</strong> allow this doctor back to work – irrespective of the circumstances as to assault a patient, whilst in the context of working as a doctor is unforgivable. However, as with the rest of this consultation the examples chosen are so extreme that they verge on unethical – chosen to sway public opinion into what the GMC want to hear. It’s important to give more plausible examples, where there are always nuances.</td>
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<td>Dr Cardiff was convicted of embezzling £100K from a charity. He has expressed regret</td>
<td>Again this needs to be in the context of when and whether this charity had anything to do with his role as a doctor. We are not sure that it is relevant to the GMC what doctors do in their private lives if this does not affect their role as a clinician – or a medical manager. The case you give is of a large sum of money – and we imagine this why this example has been picked – what if it were for £20 - so trying to dodge a fare on a train? Or what if the doctor were a Director of a company that was found to be embezzling money? What about issues relating to falsifying personal accounts for the HMRC or tax evasion via a competent accountant. What if the doctor concerned was a manager in a FT that ran a huge deficit due to mismanagement of resources or unnecessary structural reorganisations? We think that the GMC should not stray into territory that it doesn’t understand and leave the Courts to deal with cases such as this – and use the GMC to deal with cases around patients’ issues.</td>
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|   | Dr Glasgow has used obsolete surgical techniques with poor outcomes (including several deaths) for patients. She blamed nursing staff for her failures. However she has since undergone retraining. | to guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors | We think that if it were the case that this doctor failed to keep up to date and ignored best practice and continued to perform obsolete procedures then he/she should be sanctioned, irrespective of whether he/she apologises. However, why has this not been identified during appraisal or audit – and again this extreme example is unlikely to ever happen in ‘real-life’.

In addition, it’s important that the GMC does not stifle innovative practice and prevent those who might not be preforming as “the crowd” but nevertheless deliver better practice.

So for example, when GPs started managing drug users in the 1990’s they were seen to be out of kilter from the main stream within the profession (mainly psychiatry). The former were giving high doses for longer periods (maintenance) and the latter, smaller doses for much shorter periods (detox). GPs were prescribing substitute treatment for benzodiazepine addiction. As time passed – evidence showed the GPs to be correct and that many lives were saved by their approach to care – but not before a number of GPs were sanctioned for their clinical practice.

It is not enough to say that the GPs should do the studies to prove what they did was right – they were caring for patients and had no time to do the necessary research. So be careful. Also, which experts would be giving evidence? – it is always easy to get an expert to give an opinion and this could then end up as a sanction imposed because one expert overrode the opinion of another.

|   | Dr Belfast works at a mental health inpatient facility. Over 3 months he regularly notices patients lying in soiled sheets complaining they’ve not been given any water. His concern but does not take any action | to guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence | This is so difficult as it has to depend on the context.

The example is very odd and so loosely worded as to almost make no sense. How does anyone know the doctor has noticed? Did he write it down or tell someone? The system and culture are likely to be at fault here – the system that allows this clinical scenario to arise is likely to be the same system that allows this junior doctor to struggle on unsupported, and to make him fear for his career should he blow the whistle.

The GMC punishing the (easily identifiable) individual rather than the (more difficult to pin down) system / culture just extends institutional bullying.

Certainly to stand-by and observe gross mistreatment is a failure - and doctors should not just watch grossly bad care, but beyond this it is very hard to make hard and fast rules. The doctor may be in genuine fear of... |
retribution or even his livelihood.

It might be better for the GMC to lobby for regulation of managers who set the criteria and staffing levels that foster poor practice - in general it is never a good idea to go for the front line - but rather those that decide what happens.

The GMC also needs to take into consideration the doctor's rank - e.g. if he/she is an F1 trainee there would be a lesser responsibility than a consultant. We also worry about malicious allegations and that the GMC are colluding in the creation of a culture of fear, tale-telling, and bullying - all in response to system failures.

On a general basis the GMC needs to be very much clearer about the definition of words in the document - e.g. what is serious, what is harm, what is departure etc., For instance, the definition of exceptional circumstances that is proposed is virtually meaningless so it is not clear what this consultation question might lead to.

This proposal is deeply worrying as it would enable sanctions against almost all doctors for omissions in matters that are not under their direct control, which may often be identified only with hindsight, and which are more properly the direct concern of other health professionals, management and various inspectorates. It increases potential for doctors to be scapegoated for failings that largely derive from political management decisions.

The likelihood of unwanted effects of such a measure is extremely high in much the same way as excessive adherence to health and safety culture becomes oppressive and can paralyse activity.

It is likely to destabilise the NHS, as doctors will inundate management with examples of where they think systems are less than perfect and may refuse to treat patients until perfect conditions are achieved.

This example is very clearly linked to the mid Staffordshire scandal and indicates that the GMC is responding to political pressure. To some extent this is necessary and appropriate, but it must consider very much more carefully the implications of the recommendations it is making.
| 5 | Mr. London, the on-call A&E consultant is rude and aggressive towards a doctor in training who asks him to see a patient (Isaac) whom he does not feel sufficiently experienced to manage. Delays caused by Mr. London’s refusal to see the patient lead to a deterioration in Isaac’s state and another consultant intervenes to make an immediate transfer to intensive care. 

**to guide panels they may consider more serious action where cases involve a failure to work collaboratively including bullying, sexual harassment or violence or risk to patient safety.**

the preamble states that many low-level concerns about doctors working relationship can be dealt with effectively through employers local systems but states ‘we should deal with concerns that cannot be resolved locally or are particularly serious.’. 

This is so difficult. The NHS is under such pressure at the moment – with everyone working at the limits of their capacity and capability. While it is important to remove a culture of bullying, this example is about an individual within an organization. Many allegations of bullying and failure to work with colleagues are extremely complex with faults on all sides. They may simply indicate that the whole service is dysfunctional. 

Anything that gives the GMC more of a role is just going to encourage escalation of cases with doctors referring each other to the GMC including pre-emptive referrals. This will compound workplace stress and be counter-productive to the good of patients. 

What we need is for the GMC to lobby to improve compassion, kindness, empathy and remove the culture of fear for those working in the NHS – not create yet more sanctions for things that will be largely out of their control.

We also need to address the causes of poor behavior – which include: 
- poor staffing levels 
- excessive monitoring 
- bullying nature of many managers.

Would this case be different is it were transferred to a medical ward. This is a clear example of the GMC trying to make the case as extreme as possible to sway the response.

Why is the health of the consultant not considered? How do we know he has not just had traumatic experience with a patient, or a family member fall ill.

| 6 | After a few sessions of bereavement counseling, Mr. Edinburgh invites a patient to a romantic dinner. She later finds out that he has a track record of trying to establish sexual relationships with recently bereaved patients.

**to guide panels to consider removing doctors from the medical register when abuse of their professional position involves predatory behaviour towards a patient, particularly where the patient is vulnerable**

Not sure why this scenario has been chosen! It is so extreme and if the GMC will be amending their sanctions on the basis of this we would be concerned.

This doctor is obviously breaching his regulatory code and needs to be sanctioned – and possibly reported to the police – but again the GMC have chosen salacious cases to make a point. This scenario is covered by existing sanctions and guidance so what is new here?

In addition, if the patient can find all this out she could easily have done so before the dinner-date. This is just nonsense. What is the GMC’s definition of predatory, and who decides if the patient is vulnerable. Are these mutually exclusive? Might the predator also be vulnerable as well as the patient? At PHP we have examples where doctors have been lured into inappropriate

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**Supporting the health of health practitioners.**
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<td><strong>Dr Wrexham makes offensive homophobic remarks to a same-sex couple seeking NHS fertility treatment</strong></td>
<td><em>to guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics in any circumstance, either within or outside their professional life</em></td>
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<td>Doctors who breach the provisions of the equality act 2010 will, in any case, be vulnerable to prosecution. If personal prejudice impacts on the services they provide to patients they will surely be in breach of guidance anyway and to suggest that the sanctions should be increased over and above what they are at the moment reflects further desire to punish doctors.</td>
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<td>Many of these cases will rest on one person’s word against another’s and only balance of probability burden of proof will be required so there is scope for major injustice. We foresee cases where doctors are “sucked” into GMC proceedings as soon as an employee, colleague or patient accuses them of some sort of discrimination regardless of whether that claim can be independently verified. This is potentially a major issue as such accusations are quite common. Some are justified but many will be aware of people whose reaction to anything they find threatening is to allege discrimination. Facilitating the escalation of such cases to GMC investigation will be very damaging and will not enhance tolerance or patient safety.</td>
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| **Dr Birmingham, in the midst of difficult, protracted divorce proceedings, injured his wife causing severe bruising to her wrists and hit his 7-year-old son, fracturing his skull** | *to guide panels to consider the factors which may lead to more serious action where the following issues arise in a doctor’s personal life:*  
  - misconduct involving violence or offences of a sexual nature  
  - concerns about their behaviour towards children or vulnerable adults  
  - concerns about probity (being honest and trustworthy and acting with integrity)  
  - misuse of alcohol or drugs leading to a criminal conviction or caution  
  - unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation |
|   | This case history example involves a criminal offence - why should this change be necessary to cover it?  
On the other hand, any extension of GMC powers may be used as a weapon in disputes between neighbours over boundaries, and in divorce proceedings maybe even when there are disputes about facts in car accidents. ‘Ah, you're a doctor, accept my version of events or I'll refer you to the GMC’.  
The GMC should not be involved in what happens in a doctor’s living or bedroom – and restrict itself, almost without exception, to what happens in the consulting room.  
The examples that will be presented to the GMC would be so wide ranging as to invite complaints about almost any aspect of the doctor’s life. Note that there only have to be ‘concerns’ not proven criminality.  
There is a vast scope for malicious and vexatious allegations, including in |
- *any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings. The list is not exhaustive—*if there are other specific issues you think we should consider, please include them in the comment box…

marital disputes. The GMC MPTS is not a court of law so complainants have no legally enforceable duty of full disclosure, cannot be found in contempt of proceedings or made liable for costs. In our experience working with doctors—disgruntled wives, lovers often make complaints about assault—*as do children. And if the GMC act as a quasi police service—*then this would be extremely regrettable. Better to focus on what the GMC should be doing—*i.e. protecting patients.

A doctor who disowns/disinherits their adult child because they marry outside their (minority) race/religion might now be liable for sanction by the GMC—*We have known this to occur and it will be interesting to see the GMC’s response if/when a complaint is made. This example is extraordinary and again we are concerned as to the examples chosen. It should not be the role of the GMC to pile additional punishment on top of someone whom society is already dealing with.

| 9 | Dr Durham and Dr Oxford took illegal drugs at a nightclub. Whereas Dr Oxford was off sick from work next day, Dr Durham went to work while still under the influence. He stole morphine intended for a patient which he self-administered before going to theatre | to guide panels that they may consider specific factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. We take all issues related to drug or alcohol misuse seriously. Some are more serious and have aggravating features and therefore would attract more serious outcomes. We believe panels should consider more serious action in cases involving the following factors:

- intoxication in the workplace or while on duty
- misuse of alcohol or drugs that have impacted on the doctors clinical performance and cause serious harm to patients or put public safety at serious risk
- misuse of alcohol or drugs that has resulted in violence, bullying or mis-conduct of a sexual nature
- misuse of alcohol or drugs that led to a criminal conviction particularly where custodial sentence was imposed

This approach is consistent with our guidance on assessing the risk posed by doctors with health issues. | The case study involves criminal offences so it’s not clear what the new guidance would add. |
Section 2: the role of insight and apology

Q 10: Do you think panels should require a doctor to apologise where patients have been harmed?
There are 2 issues: 1) a forced apology, even if warranted, has little value and few patients are likely to be impressed by it 2) Good Medical Practice requires doctors to apologise when appropriate. Doctors will often not have thought to ‘apologise’ when complications occur that are common and/or that the patient has previously accepted may happen and that could not reasonably have been avoided. However, the GMC seems to be joining a bandwagon of demanding apology for apology’s sake whenever a patient experiences harm or distress, regardless of whether this reflects poor care. This approach devalues apology, and devalues the patient’s role as a partner in decisions about their care. Those decisions involve accepting that things may not turn out well, even where the care has been of the highest standard. The GMC wants doctors to come off their pedestal yet still to shoulder all the responsibility for life being imperfect. Doctors should empathise with the patient: it is polite to say one is sorry that it has turned out badly but the focus on apologising early on adds to the low morale in the medical profession. This is currently evidenced in poor recruitment and retention and contributes to doctors avoiding high-risk patients and procedures. This is directly contrary to the interests of patients.

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| 11 | Dr Swansea failed to properly examine or assess vulnerable residents in a care home. This led to the avoidable death of 5 elderly patients and he failed to be open and honest with bereaved relatives and refused to apologise. He apologises on the day before the hearing is due to start but fails to tell the truth when giving evidence. | to introduce more detailed guidance on the factors that indicate a doctor has all lacks insight  
- a doctor is likely to have genuine insight if they accept they should have behaved differently, consistently express insight (demonstration of genuine reflection and remediation), take steps to remediate and apologise at an early stage before the hearing  
- a doctor is likely to lack insight if they: refuse to apologise accept their mistakes, do not consistently express insight, or fail to tell the truth during the hearing  
- a doctor may also lack insight if they promise to remediate, but failed to take appropriate steps or only do so when prompted or immediately before or during the hearing | This is all acceptable as evidence of lack of insight but pre-supposes that it has been possible to reach a fair and accurate judgment about whether a doctor has been at fault. The example presented may well meet those criteria but, unfortunately, there are many cases where there would be varying views about whether or not the doctor has acted appropriately, especially in more complex cases where there is a range of accepted practice and which may often be very difficult for non-specialists to understand.  
Some expert witnesses retained by the GMC have a chequered history of knowing the limits of their own knowledge and the panel is likely to depend heavily on such witnesses.  
The burden of proof applied since 2008 has been the balance of probability and only 2 out of 3 panelists would need to find against the doctor. It is therefore plausible that a doctor who contests the view that he has not acted appropriately might be correct in many other doctors’ views. The introduction of more ‘insight’ tests in these circumstances will compound injustice. |
| 12 | Dr Lisburn is 6 weeks into training in trauma and orthopaedics. He uploads several radiographs of patients fractures onto his Facebook page. | To guide panels they may consider the stage of the doctors UK medical career as a mitigating factor, and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. However in cases involving... | This seems reasonable but again depends on the circumstances.  
The example you give of uploading X-rays needs dealing with - but not necessarily through a GMC process. You then ask about predatory behaviour. Clearly this is an order of difference and should be dealt with differently. We think it depends on how long ago, what were the... |
serious concerns about a doctor’s performance or conduct (e.g. predatory behaviour to establish a relationship with the patient, or serious dishonesty), the stage of the doctor’s medical career should not influence the panel’s decision on what action to take.

circumstances and whether in the context of the doctor’s culture this might have been seen as ‘normal’.

So for example, PHP has met several overseas trained doctors who have been in prison - for crimes that might be related to an officious dictatorial regime. If you simply judged the doctor on whether they had been in prison then you might impose a sanction or not allow registration. But if you knew it was because they had refused to comply with behaviours expected of them - e.g exposing a patient whom the state believed might be a subversive, then how would the GMC act - and how could it prove this assuming that documents and proof would be hard to come by.

Of course if the doctor themselves were a torturer and had spent time in prison for this - it might sway your decision - but what if they had been a child soldier - had killed or even tortured several people before? How would the GMC respond? We think better that the GMC ensures equity and fairness first rather than becomes the international detective.

Dr Reading persistently sexually harassed 3 female colleagues over 12 months despite their rejecting his advances. One doctoral was signed off with stress as a result. Dr Redding has provided 30 testimonials from neighbours detailing youth projects he set up in the community but none from colleagues or patients.

to introduce guidance for panels on the factors they may consider when deciding whether testimonial are relevant to their decision: whether the testimonial is relevant to the specific concerns about the doctor.

The extent to which the views expressed in the testimonial are supported by other available evidence how long the author has known the doctor how recently the author has had experience of the doctors behaviour or work the relationship between the author and the doctor (e.g. a senior colleague) whether there is any evidence that the author has a conflict of interest in providing the testimonial (e.g. personal friendship)

Q13 - if we introduce verification checks on testimonials, do you agree we should continue to accept them as evidence? Q 14 do you agree we should use the factors above to decide whether testimonials are relevant to the panel’s decision?

If the GMC’s aim is to protect patients interests rather than act as a free litigation service for individuals, they must seek information that reflects, at a minimum, a doctor’s work record and extent of his practice over a period of some years.

If there have been clinical adverse events it is essential to get some idea of the denominator.

It is also important to know whether a doctor has a very good track record of clinical achievement, in which case suspending him would be a potential loss to other patients. For these reasons, testimonials are very important evidence but it is certainly reasonable to verify them.

People providing testimonials should be asked to state their relationship to the doctor e.g. colleague, personal friend etc – perhaps a proforma should be supplied with a check-list. None should be ruled out especially as many colleagues would class themselves as friends in that they may socialise without necessarily being close personal friends and a doctor should not be deprived of colleagues’ testimonials in these circumstances. We are reaching the bizarre situation where testimonials are subject to greater scrutiny than medical evidence supplied by GMC psychiatrists.
Dry Birmingham’s responsible officer is asked to provide a statement on the extent to which Dr Birmingham has shown insight and remediation in the workplace. The RO confirms stock to Birmingham is complying with interim conditions and there have been no further complaints about his behaviour. To make sure we routinely request a statement from the doctors responsible officer during our investigation for the panel to consider at a hearing. The statement should set out the extent to which Dr has reflected on the matter before the panel, the extent to which they have shown insight and how far any issues about their performance behaviour have been addressed. The panel may wish to consider the extent to which any evidence of inciting testimonials provided on the doctor’s behalf is supported by other available evidence, including the responsible officer statement. We would also introduce guidance for panels to make sure doctors who do not have a responsible officer because they have given up their licence, although using alternative routes revalidation, are not treated unfavorably.

This appears to be a humiliating process - and considering your earlier questions you would ignore anyway. Also it adds another layer of investigation and process into one that is already onerous and prolonged. The GMC has to trust its own processes - and revise them to make them shorter. But it has a panel, it has case examiners, employment officers, GMC appointed psychiatrists, expert witnesses and more. Cases can take 3 years before being aired. It is important that nothing is done that prolongs this process.

How are you going to measure ‘reflection” and by whom and what is the inter-rater reliability?
**Section 3: changes to our guidance on suspension and Section 4: giving patients a voice**

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<td>Dr Hull failed to act on a case of unusual bruising in an 18-month-old that was not consistent with the mother’s explanation of the injuries. 3 months later the child died after brain injury caused by aggressive shaking. Dr Hull expressed remorse for failing to spot child abuse, recognises the seriousness and has undertaken several courses to help spot signs of child cruelty in future.</td>
<td><strong>To guide panels they may consider 5 key factors when deciding the length of suspension:</strong>&lt;br&gt;• The risk to patient safety&lt;br&gt;• The impact of public confidence in doctors the seriousness of the concerns, and any mitigating or aggravating factors&lt;br&gt;• Sending a message to the medical profession that standards must be upheld&lt;br&gt;• Ensuring the doctor has adequate time to remediate&lt;br&gt;• Panels may also wish to consider the time all parties may need to prepare for a review hearing if one is needed</td>
<td>The 2nd and 3rd bullet points here seem to be the same. They raise the spectre of trial by media because the likely way this case would impact on public confidence or sending a message to other doctors is through media coverage which may be inaccurate. This case is worrying as there is a danger – seen in well known cases – of doctors being scapegoated for the failings of others, including the criminal perpetrators of the abuse. Some on the list we agree. But “sending a message” - is ‘pour encourager les autres’ and has never been a good maxim. It is important to judge the case on its own merit. What does this mean? Sounds like “sending a message that we will make an example of you if we catch you” Is this the compassionate health service discussed in Francis? Again the issue of public confidence - you have asked this in a previous question. You need to determine whether it’s public confidence or public prejudice and whether it’s the public or the Daily Mail you are concerned about. Doctors have little confidence in the GMC process and doctors are members of the public – it’s important that you make your process fair, safe, and proportionate. In our experience doctors are hard wired to feel guilty when ever they are involved in a patient death or error. This happens from the outset.</td>
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<td>Suspending doctors with health issues–no case history provided.</td>
<td><strong>Where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration</strong></td>
<td>This seems reasonable, as long as the restrictions are properly informed by expert occupational health reports. This is a complicated issue and the question does not do justice to the multiplicity of issues that could and should be considered. There of course should be a bar or a threshold, and if the doctor in question reaches that threshold then of course the GMC should suspend the doctor - for example - frank psychosis where the doctor has committed an offence that is serious - for example killed or maimed someone.</td>
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But if the doctor is psychotic and has removed himself from work and is seeking help - (or even if not) then why does the GMC need to suspend - anymore than if the same doctor had fractured his leg and was seeking help (or not) and was not working in the process.

It is important not to discriminate against mental health - which this question is at risk of doing. Instead it's important that the GMC acts humanely and supportively and should set up a practitioner health service to deal with the vast majority of health cases.

Being unwell is not a crime and the GMC needs to ensure that it does not treat sick doctors as criminal - it also needs to work to evidence. At present the evidence where doctors who have health problems have harmed patients is weak, this is important as without evidence we are working on prejudice - rather like those who believed that patients with schizophrenia were responsible for violent crimes against people - till the evidence showed they were more likely to be victims of violent crime than perpetrators. Ditto doctors with mental health problems.

| 18 | Dr Aberdeen was suspended for 6 months after she repeatedly provided false information about CPD courses. To keep her clinical skills up-to-date during this period she found a placement shadowing colleagues so she could observe consultations. | To provide guidance that suspended doctors should keep their clinical skills up-to-date by working in ways that do not allow them to be able to play any part in interactions with patients. This would still enable them to observe and later reflect on clinical care such as observing clinics related to their area of practice and of course by engaging in continuing professional development. | It is not clear whether there will be any help/support for doctors in finding such placements. This may be necessary as doctors may otherwise face conditions that are very difficult to fulfill. It is important that the GMC presents evidence that this recommendation is needed. In our experience suspended doctors are banished from their employers and except in exceptional circumstances find it very difficult to carry out any health (not front end patient) work whilst suspended - even for example summarizing notes or working as a receptionist. The GMC needs to look at its systems in the whole and try and improve the process and decide what it is about and how it works. It also need to use evidence and then if necessary change or introduce new recommendations. |
| 19 | Dr Newport has been subject to 18-month interim suspension following his being verbally aggressive to several patients and physically assaulting a colleague during a locum placement. An FTP panel has now found him impaired because he continues to present a risk to the public. | Consider issue of whether panels should take account of previous interim suspension orders in a panel sanction decision on suspension where action is solely to uphold public confidence in doctors - Where a panel suspends adopters solely to uphold public confidence in doctors, should any previous interim order influence the panel’s decision? | We cannot understand how the case study relates to the consultation question – the doctor is considered to still present a risk whereas the question is about the situation where any suspension is solely to uphold public confidence. |
| 20  | Tom's leg had to be amputated because of wound infection due to Dr Colchester's failure to comply with basic hygiene. He meet with Dr Colchester to explain how this affected him and ask questions to help them understand what went wrong | issue to consider: the benefits of meetings between doctors and patients where doctors actions have seriously harmed a patient

Q: *do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed?*

|  | The example is somewhat facile. We cannot think of a situation where it would be ethical and proportionate to suspend a doctor solely to uphold public confidence, especially when the public has made no contribution to the concept and the doctor has not been made aware of the test by which his actions are being judged |  |
### Section 5: changes to our powers to give warnings

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<td>Dr Derby is convicted of causing death by careless driving, suspended from driving for 18 months and given a community order. This is an isolated incident, she has demonstrated significant insight through voluntary work with the local road safety charity. Following legislative change, a panel would have the option to find the doctor's fitness to practice.</td>
<td>Q 21 do you think warnings are an effective and proportionate means of dealing with low-level concerns which involve a significant departure from good medical practice?</td>
<td>Warnings can have a very detrimental effect on a doctor’s career, reputation and remuneration. They can be issued by case examiners without hearing of evidence, thus minimal opportunity for defence. This is not proportionate to 'low level' (otherwise undefined) concerns, particularly given that the explosion of guidance has created so many potential offences.</td>
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<td>Action to deal with misconduct: How effective and proportionate is our current warning system, when should we be able to issue warnings, and should more serious action be taken effective and proportionate means of dealing with low-level concerns, which involve a significant departure from good medical practice? Impaired and issue a warning</td>
<td>Q 22 when do you think we should be able to give warnings? a) not in any circumstances, b) only to deal with low-level concerns that involve a significant departure from good medical practice where a doctor's fitness to practise is not impaired, c) only to deal with misconduct where a doctor's fitness to practice has been found impaired: d) to deal with low-level concerns or misconduct (see b and c) if different terms are used to describe them</td>
<td>If warnings are appropriate at all, it should only be following a proper examination of evidence at a hearing. If warnings are only appropriate for low-level concerns, those must be current and some degree of impairment must have been determined. The GMC should not be a 2nd tier of punishment for those convicted by the courts. Also employed doctors are liable for internal disciplinary proceedings within their employment so the GMC should not have to wade in.</td>
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<td>Q23 If we continue to give warnings do you agree that more serious action should be taken where there are repeated low-level concerns that involve a significant departure from good medical practice</td>
<td>Q24: How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practice is not impaired? A. Publish warnings for 5 years and disclose to employers and responsible officers indefinitely B. The publish warnings for one year and disclose to employers and responsible officers for 5 years See issue guidance to case examiners and METS panels on determining length of publication on a case-by-case basis and to a maximum of 5 years. In definite disclosure to employers and responsible officers</td>
<td>Define ‘low-level concerns’. The danger is that this just means less than 100% perfect as judged against a set of guidelines that those judging have often not had to comply with themselves to any appreciable extent.</td>
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<td>To publish them is a breach of confidentiality that cannot be justified on grounds of public safety because the doctor's FTP is not impaired. It is difficult to see how publishing warnings in such cases contributes to confidence in the profession.</td>
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<td>Indefinite disclosure to employers and responsible officers is grossly disproportionate and does not reflect normal HR practice or, employment law – in normal (i.e. non doctor) situations, warnings can only kept on file for 5 years maximum and an employment lawyer told me I could not use an recently expired warning that I knew about as evidence in a fresh hearing.</td>
<td>You must define ‘repeated” as otherwise it is open to unfair interpretation</td>
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