BMA Scotland

Draft Statutory Instrument:

The General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References To Court) Order 2015

Establishing the MPTS as a statutory committee of the GMC

The BMA agrees with the proposal in this draft order to establish the MPTS (Medical Practitioners Tribunal Service) as a statutory committee of the GMC to govern the adjudication of fitness to practise processes for doctors.

The following submission highlights some of the broad areas of concern highlighted during the UK Government’s consultation process and which should be considered as part of the legislative process and in the preparation of supporting guidance.

Modernising the MTPS’ adjudication function including strengthening the case management arrangements

During the UK Government’s consultation process, the BMA expressed a view that whilst we supported the appointment of case managers, we opposed any measure that would imply that there was a requirement for a chair to be legally qualified in order to be a case manager – which would exclude doctors from the role. We think that doctors should continue to be able to be chairs with the support of legal assessors. The draft Order suggests that a medical tribunal chair (where legally qualified) could be appointed case manager. Whilst the order allows for the appointment of a legally qualified case manager should the chair not be legally qualified, there is a risk that this could act as a deterrent to appoint non-legally qualified chairs and should be clarified in guidance.

The BMA agrees with the proposals that enable reviews without hearing, where both parties are in agreement as to the outcome. However the BMA disagrees with the proposal to provide notification of decisions relating to fitness to practise by email rather than letter. It is our view that an email does not provide a guarantee of recorded delivery. In the consultation response, we suggested that email be used alongside a letter sent by recorded delivery. It is crucially important for the panel to have confidence that the doctor has received notice of the hearing and therefore been provided with an opportunity to attend. While communicating by email may save time and cost in some cases, it could lead to adjournments and delay if the panel is not satisfied that the GMC has provided clear evidence of the doctor’s intention not to attend a hearing.

Addressing patient safety issues and enhancing confidence and accountability

The BMA agrees that the overarching objective should be to protect the health and safety of the public. The purpose of fitness to practise proceedings should be to determine whether a doctor is fit to practise and should not be viewed as
punitive. During the consultation process we raised concerns that the proposal left room for panels to punish doctors who pose no threat to the health or safety of the public on the basis that failure to do so would undermine public confidence. This could lead to 'trial by media' and it would be essential that this is not the case.

Guidance should make clear to panels that they should not assess public confidence on the basis of purely personal condemnation of the conduct found or the media’s response to it.

We would also suggest that the guidance should make clear to panels that they should continue to ask whether a doctors’ progress towards remediation satisfies any legitimate ‘public confidence’ concerns.

The proposals make amendments to the Medical Act in relation to professional performance assessments and include express provisions relating to health assessments and provisions that would allow MPTS to include up to 12 months suspension for non-compliance. During the consultation process, the BMA urged that the power to suspend a doctor for up to 12 months should only be used where there is clear evidence of wilful failure to comply and only in exceptional circumstances.

17 February 2015

Yours sincerely,

Dr Peter Bennie
Chair, BMA Scotland
The Medical Defence Union

General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015 [draft]

Introduction

1. In September 2014 the MDU responded on behalf of our medical members (over 50% of the UK’s doctors in hospital and general practice) to the English Department of Health’s consultation on proposed changes to modernise and reform adjudication of the General Medical Council’s fitness to practise (FTP) procedures. The consultation included a draft S60 order and the MDU’s response also referred to that draft order.

2. The DoH published its report on the consultation on 16 January and as a result of that consultation made some amendments to the draft S60 order which has now been laid before the UK parliaments as the General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health & Social Care Order (References to Court) 2015.

3. In the MDU’s response to the original consultation we agreed with some of the proposals and did not support others. The DoH consultation response report made some amendments that addressed some of the concerns the MDU had raised, but the draft regulation that has now been laid before the Parliament contains some regulations where the MDU’s concerns still remain. Mindful of the 2,000 word limit, we are providing the Health & Sports Committee only with details of our main concerns, in the order of the regulations to which they refer.

Regulation 8(5)

4. This would provide the Medical Practitioners Tribunal Service with powers including those of refusing to admit evidence, drawing adverse inferences and of awarding costs (or expenses in Scotland) where a party’s or a party’s representative’s conduct of the proceedings has been unreasonable.

5. The MDU objected to these proposed powers on a number of grounds which we set out in our consultation response and which were not addressed in the DoH consultation response report or the revised regulation.

6. We set out our concerns in respect of costs sanctions first:

   - Costs sanctions would be punitive for registrants. Doctors will have to fund costs sanctions - twice - as they will have to be reflected in their defence costs and also in the annual retention fees they pay to the GMC. It is unfair that defendant doctors should be at risk of funding
costs for either party when they have very little control over proceedings and are in the vulnerable position of having to rely on other parties to comply.

- None of the bodies seeking the powers to introduce costs sanctions (DoH, GMC or MPTS) has provided any evidence that a problem exists whereby costs sanctions are the only effective solution.

- No financial rationale has been provided for the proposed sanctions. The MDU has not seen any documents setting out the estimated extent of the additional cost and its financial impact on doctors who are already funding their prosecution as registrants, as well as their defence costs.

- Costs sanctions that could fall on the GMC and/or on the defendant doctor/defendant doctor’s representative, but that are ultimately paid by registrant doctors, are contrary to the Department of Health’s stated policy to minimise the costs of regulation and their impact on individual healthcare professionals.

- Costs sanctions are likely to be most punitive on doctors who are defending themselves. These are doctors who are not members of medical defence organisations or similar bodies and who are unfamiliar with MPTS procedures and therefore potentially more likely to incur costs sanctions for non-compliance. GMC data demonstrates that unrepresented doctors are very often doctors from overseas, and cost sanctions would have a disproportionate effect on this group of doctors.

- Disputes about the appropriateness of cost sanctions will further increase the cost of regulation. In the MDU’s experience cost sanctions in other areas of law lead to satellite litigation and we expect this will happen as parties are likely to contest MPTS costs order.

7. Costs penalties may be thought to work in the civil courts, though this is not the view of the MDU which has considerable experience as a defendant in civil procedures. Our view is that costs sanctions often lead to costly satellite litigation which further increases the cost. However a regulator’s disciplinary tribunal is not analogous to the civil courts. If MPTS ever intended to introduce costs sanctions, it would need to provide a very clear cost/benefit analysis setting out the precise extent of the ‘problem’ that costs sanctions are supposed to remedy, in the context of the current experience of case management and to equate that with the scale of the costs it intends to impose.

8. Even assuming there is a problem with case management (and the MDU has been provided with no evidence of such a problem), there are far more effective ways to ensure cases proceed swiftly and efficiently. It is in registrants’ interests that such methods are exhausted before any additional financial burdens are imposed upon them. On behalf of our members, the MDU would be very keen to work with the
GMC/MPTS to explore these methods further and to offer our own experience of what works in terms of effective case management.

Refusal to admit evidence and adverse inferences

9. The MDU strongly objects to the proposed introduction of powers to prevent admissible evidence from being given, or that there might be an adverse inference drawn. We consider these sanctions to be punitive in purpose in circumstances where there is no evidence that such sanctions are necessary or any rationale provided as to why they would be relevant or helpful in a procedure which incorporates the purpose of protection of patients. It is our view that such sanctions are more likely to be counter-productive, increase the cost and time of hearings and, in some cases to give rise to submissions that they are not Article 6 compliant.

10. It is difficult to see how a refusal to admit evidence which might be vital to a case because of a failure to comply with rules could ever be appropriate. For example, if it was alleged that the GMC had not complied with the rules, and evidence for the GMC were to be excluded in relation to an allegation from a patient, how could that be consistent with public protection and/or ensuring a case was being dealt with fairly and justly? If defence evidence were to be excluded, that would not be fair or just, or in all probability be Article 6 compliant. We believe a proposal to exclude evidence as a punitive measure on either party is inconsistent with a purpose of the procedure being protection of the public. Such a move is also very likely to give rise to disagreement in the course of a panel hearing about the exclusion of evidence, which would inevitably result in additional time being spent hearing such arguments, and then further time added if the dispute followed through to the panel deliberation.

11. We believe the proposal in relation to the ability to draw an adverse inference is similarly flawed. Beyond that, it is difficult to see how it could be sensibly applied by an MPTS panel. In criminal proceedings, a jury may be permitted to consider if a defendant was telling the truth when giving evidence, if the defendant didn’t answer questions he or she could have been expected to address at police interview, or if the account to the court differs from that given to the police. An adverse inference is understandable in that context; but the adjudicatory process run by MPTS is not a criminal court and failure to comply with directions is a very different matter to a defendant knowingly withholding information. A failure to comply with a direction does not of itself show that the integrity of evidence is compromised. Again, the result of such a provision would in many cases be to increase the length, and cost of, panel hearings because time would have to be spent considering whether the panel could draw any inference. The panel would also have to consider how any ‘adverse inference’ could operate sensibly in relation to the evidence. This would then be likely to follow through to the decision making process of the panel, with further time and money being added in consequence.
12. We do not believe this proposal has been thought through carefully in respect of the potential practical effect. Panel hearing dates are fixed a number of months in advance. Almost inevitably, any problems with non-compliance with directions are likely to arise closer to the time of the hearing, and after the hearing date is fixed. It would seem illogical when fixing a hearing date to allow for additional time just in case there is a dispute about non-compliance, but there is no other time when those disputes could take place. In consequence there is a real danger there might be insufficient time to conclude a case in the allocated time, so that a hearing might have to be adjourned for a number of months. Such a position would be inappropriate and unfair to all concerned.

Regulation 21

13. We strongly oppose the change this regulation would introduce because we consider its purpose to be punitive. It is not currently the role of the GMC to punish doctors, and it should not be given such powers.

14. There is no need for the GMC to state an over-arching objective in the primary legislation. In practice MPTS panels already can and do reflect these objectives in their decisions to the extent that is appropriate. For example the recent case of Hussein on the MPTS website includes the following in the panel's determination: 'In considering impairment, the panel has borne in mind the public interest, including the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding or proper standards of conduct and behaviour.' MPTS panels clearly can and do pay proper regard to such objectives to the extent that is necessary. Enshrining them in primary legislation may well result in a panel placing an emphasis on them to the detriment of the fundamental responsibility of the panel to ensure a fair and just hearing.

Regulation 22

15. We do not agree to the removal of the test of ‘exceptional circumstances’. It is unreasonable to expect doctors to be in jeopardy of an FTP investigation at any time without the protection of the need for evidence that the circumstances are exceptional. The consultation document suggested there was a developing body of case law but did not cite that law nor give any examples of the sort of cases it would consider it in the public interest to pursue potentially very many years after the event. The DoH report on the consultation also failed to address this important point.

16. It will always be the case that a doctor who is investigated on a matter that took place more than 5 years ago will be under a considerable disadvantage in providing a defence because of the passage of time and the inevitable change in circumstances that will have resulted. We cannot think of any grounds, other than exceptional circumstances, that
would be serious enough to warrant the unfairness of an investigation out of the blue and many years after an alleged incident.

17 February 2015
The Medical Defence Union