



Department
of Health

The General Medical Council and Professional Standards Authority: Proposed changes to modernise and reform the adjudication of fitness to practise cases

Consultation Response Report: January 2015

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The General Medical Council and Professional Standards Authority: Proposed changes to modernise and reform the adjudication of fitness to practise cases

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**Prepared by the Professional Standards Branch, Strategy and External Relations
Directorate, Department of Health**

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Executive summary

The Department of Health undertook a UK-wide consultation on making changes to the way that the General Medical Council (GMC) makes decisions about doctors' fitness to practise between 31 July and 25 September 2014. The main proposal in the consultation paper was to establish the Medical Practitioners Tribunal Service (MPTS) as a statutory committee of the GMC to strengthen and protect the independence of decision-making at the adjudication stage of the fitness to practise procedures. It also contained other proposed reforms to the GMC's fitness to practise procedures and to its regulatory objectives. The consultation paper also proposed improvements to the grounds of the Professional Standards Authority's (the PSA's) power to refer cases to the higher courts.

The proposed reforms require change to both the Medical Act 1983 and the NHS Reform and Healthcare Professionals Act 2002. The proposed means of doing this is by amendment by an Order under Section 60 of the Health Act 1999. A draft amendment order was published alongside the consultation paper.

As the proposals relating to the changes to the PSA's grounds for references to the higher courts also apply in respect of those professions for which responsibility is devolved, the consultation was undertaken jointly with Scottish Ministers.

In the consultation paper, the proposals were split into four main groups:

- Establishing the MPTS as a statutory committee of the GMC specifying its powers, responsibilities and duties.
- Modernising the MPTS' adjudication function including strengthening case management arrangements.
- Addressing patient safety issues and enhancing the accountability of medical professionals and other healthcare professionals.
- Clarifying a number of areas of the Medical Act to make the procedures and their scope simpler to understand and more transparent.

The consultation received 81 responses from a range of respondents including medical and legal professionals, healthcare recruitment organisations, regulatory bodies and members of the public.

The consultation responses demonstrated strong support for the principle of enhancing the separation between the GMC's role in investigating fitness to practise concerns and its role in adjudicating on whether those concerns amount to impaired fitness to practise. Establishing the MPTS as a statutory committee of the GMC with the functions set out in the draft Order, subject to modifications made in light of the government consultation, is in our view the right means of achieving this.

There was also support for proposals in the consultation paper relating to modernising the adjudication procedures, including introducing an over-riding objective to ensure that the procedural rules which govern hearings secure that cases are dealt with justly and fairly.

A range of views were expressed about the proposals to enhance public confidence and professional accountability. Some respondents felt that these measures were straight forward public protection issues while others were concerned about how they would impact on doctors undergoing the fitness to practise procedures. The Department remains of the view that public protection, in its fullest sense, must be the driving objective of the fitness to practise procedures and considers that its proposals to enhance professional accountability are a proportionate means of achieving that aim.

In relation to the proposals to simplify and increase transparency of the Medical Act 1983, there was strong support for confirming that the GMC has the power to close an allegation if the matters giving rise to are more than five years old, while removing the 'exceptional circumstances element', or because the allegation is vexatious. There was also strong support for explicitly enabling undertakings to be agreed after a referral to medical practitioner tribunal. There was less support for the proposals to strengthen the GMC's powers of investigation and the consequences for failing to comply with an assessment. However we consider that given the over-arching public protection considerations, these powers are appropriate.

Some respondents suggested changes and some responses pointed to issues which highlighted the need to make changes. We have considered these and incorporated changes into the draft section 60 order in a number of places to address some of the points that were made. Alongside these we have also noted the need for some minor corrections. We believe these changes will make the reforms more effective, proportionate and robust.

The main changes we have made are as follows:

- Clarifying that rules may provide that the criteria for appointment of MPTS members is to be set and published by the GMC.
- Explicitly prohibiting employees of the GMC from sitting on medical practitioner tribunals and interim orders tribunals.
- Explicitly prohibiting any investigation committee functions being delegated to officers acting for the MPTS. The scope of the over-riding objective to ensure that procedural rules are fair and just has been extended to cover all constitution and procedural rules governing the MPTS, medical practitioners tribunals, interim orders tribunals and investigation committee hearings when it is considering issuing a warning.
- The power to make rules for the cancellation of a referral to a tribunal has been amended so that the rules can provide for the Investigation Committee or case examiners to decide to cancel a referral as an alternative to the Registrar.
- Limiting the MPTS' discretion to not appoint a legal assessor to only those circumstances where the chair of the panel is legally qualified.
- Clarifying that the Chair of the tribunal may be appointed as case manager for the purposes of the proceedings if the Chair satisfies the same criteria as to legal

qualifications and experience as a case manager and that the tribunal itself may conduct case management.

- Introducing a rule making power to require the parties to be informed of certain advice provided by a legally qualified chair to the other tribunal members, including while they are considering issues in private, in line with that applicable to legal assessors.
- Specifying the legal qualifications and experience required for a legally qualified chair to be the same as required for a legal assessor as determined by the MPTS.
- Where the GMC and the doctor reach agreement on the appropriate outcome in a review case, enabling a whole tribunal to consider the proposed outcome as an alternative to the Chair (subject to power to nevertheless convene a full tribunal hearing to consider the case if appropriate).
- The duty to have regard to the over-arching objective will not apply to registration appeals panels and interim orders tribunals but does include decisions falling within the Investigation Committee's remit which relate to a final disposal involving the imposition of a warning or the agreement of undertakings.
- Provision so that the provision enabling email service of notice of decisions is subject to a requirement that for service to be effective there must be a read receipt for the email or it must otherwise be acknowledged.
- Technical revisions strengthening the PSA's ability to become involved when the GMC make an appeal to ensure the PSA is able to become a party and make representations or to take over the case if the GMC withdraw the appeal in circumstances where the PSA consider they should not do so.
- Introducing a requirement for the MPTS to serve the Registrar and the PSA with its decisions to ensure that there is clarity around the time allowed for the GMC to make an appeal or the PSA to make a reference.
- Extending the PSA's time for referrals in circumstances where a decision is made which is not appealable by the registrant (i.e. if no order has been made) so that it has 56 days to decide whether to refer that decision to the relevant higher court, which is a further 28 days after the GMC has decided to not appeal the case.
- Provision so that after a hearing has commenced, undertakings can only be agreed after the medical practitioners tribunal has made a determination on impairment. Such undertakings are to be agreed with the GMC not the tribunal, but can be taken into account by the tribunal. There is also power to provide in rules that in the case of any breach of undertakings, or where undertakings are no longer sufficient to manage the concern, the matter would be referred back to the medical practitioner tribunal to consider.
- Enabling any member of the current non-statutory committee of the MPTS to be appointed as a member of the MPTS in its formal statutory form.
- Require that a performance assessment must always include a medically qualified person as an assessor and for assessors to be drawn from a list of assessors appointed by the GMC in accordance with rules, and confirming that the assessors may regulate their procedures so far as not provided for in rules.

More detailed consideration can be found under the analysis of the responses to each consultation question.

Taken as a package, these reforms will not only enhance and protect the separation of functions between investigation and adjudication, but also enable the GMC to investigate more robustly and for the MPTS to consider cases in a more timely way. This will mean that the system will protect the public more effectively.

The UK government intends to lay a draft of the General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order before the Westminster Parliaments at the earliest available opportunity. The Scottish government will lay the same instrument before the Scottish Parliament.

Background

Proposals to strengthen the separation between the GMC's role of investigating fitness to practise concerns about a doctor (known as the investigation function) and the role of deciding, following referral to a panel, on whether those concerns amount to impaired fitness to practise and what, if any, restrictions on that doctors' practice might be necessary (known as the adjudication function) were first set out in the 2007 White Paper, *Trust, Assurance and Safety – the Regulation of the Health Professions in the 21st Century*. The 2007 White Paper proposed establishing a new independent body called the Office of the Health Professions Adjudicator (OHPA) to undertake the adjudication function. This was provided for by the Health and Social Care Act 2008. However, following consultation in 2010, the Government decided that enhancing independence of adjudication in fitness to practise cases relating to doctors while continuing to adequately protect patients and the public could be achieved in a more proportionate way while retaining the adjudication function within the GMC. Parliament approved the repeal of provisions relating to OHPA in the Health and Social Care Act 2012.

The GMC undertook a further consultation on strengthening the separation between its investigation and adjudication functions in 2011 and proposed establishing the Medical Practitioners Tribunal Service (MPTS) as a statutory committee of the GMC as well as other reforms to modernise the adjudication procedures. Many of these proposals were drawn from the work undertaken to develop OHPA.

This work was considered by the Law Commissions as part of their review of the legislative framework surrounding healthcare professional regulation. The purpose of that review, which was commissioned following the 2010 White Paper *Enabling Excellence*, was to make recommendations to modernise and simplify the regulatory landscape ensuring that the mechanisms to ensure patient protection were fit for the future.

The Law Commissions published its report and recommendations for legislative change on 2 April 2014 which included enabling greater separation between the investigation and adjudication functions within the fitness to practise procedures by delegating responsibility for the appointment to the pool of fitness to practise and interim orders panellists and the constitution of individual panels to a separate person or body from the Council itself. The Government will be publishing a full response to the Law Commission's recommendations in due course. It agrees with the principle of the Law Commissions' recommendations regarding enabling greater separation of functions for all regulators and would propose to do so at a suitable opportunity. In the meantime, by implementing greater separation for the GMC now the government will bring to completion the work towards this which was commenced before the Law Commissions' review. As a result we intend to lay an order under Section 60 of the Health Act 1999 (a 'section 60 order') to amend the Medical Act 1983 to establish the MPTS as a statutory committee of the GMC and to make other reforms.

Consultation process

The Department and the Scottish Ministers consulted on a UK-wide basis from 31 July 2014 to 25 September 2014 on the draft section 60 order to make the necessary amendments to establish the MPTS as a statutory committee of the GMC and other changes.

The consultation invited respondents to consider 26 questions about the effects that these provisions could have. The Department received 81 replies who identified themselves as:

Category	Number of respondents	Percentage
Medical professional	12	15%
Medical defence organisation, legal professional or law firm	10	12%
Patient representative organisations	2	2%
Organisations representing doctors	12	15%
Regulatory body	4	5%
Healthcare recruitment organisation	9	11%
Devolved administration	1	1%
Private consultancy firm	1	1%
Not answered	30	37%

Of these responses, 39 (48%) were identical responses from a co-ordinated group of individuals and organisations. A further one of these identical responses purported to be from an organisation which confirmed that it did not send it, so we have not included that.

It should be noted that not all of the respondents answered all of the questions in the consultation. One organisation also provided separate views from its clinical and lay membership. These have been counted as separate responses. Where percentages of respondents have been given, these figures have been rounded and so may not add up to 100% in all cases.

The Department would like to thank all of those who responded to this consultation and is grateful to them for their input.

Consultation responses

Establishing the MPTS as a statutory committee of the GMC

Q 1: Do you agree with the proposal that the MPTS should be set up as a statutory committee of the GMC to govern the adjudication of fitness to practise processes for doctors?

A significant proportion of respondents (52%) felt that creating an entirely independent body like OHPA, rather than establishing the MPTS as a statutory committee of the GMC was a preferable approach. This group included the group of 39 co-ordinated responses. The department's original decision not to proceed with OHPA was taken in 2011 and this was endorsed and implemented by Parliament in the Health and Social Care Act 2012. The government's proposed approach was that we should aim to enhance the independence of decision making at fitness to practise panel hearings while continuing to protect the public by retaining the adjudication function within the GMC and increasing the separation between its investigation and adjudication functions, and we consider that this is a more proportionate approach. 27% supported the proposal to establish the MPTS in this way. We consider that establishing the MPTS as a statutory committee of the GMC is the right means of achieving this. Those seeking an entirely separate body implicitly support the principle of greater separation, but they do not agree with our proposed method. However we are not persuaded to return to a policy of having a completely separate body. One respondent suggested that the GMC's adjudication function should be subsumed into Her Majesty's Courts and Tribunal Service. This was also considered as part of the 2010 consultation on the abolition of OHPA it was decided not to proceed with this option owing to practical difficulties, which would still apply.

7% of respondents, including the PSA, did not agree that the proposals to establish the MPTS as a statutory committee of the GMC would achieve the aim of additional separation. The PSA stated that legal assessors and case managers were not prohibited from being involved in the investigation stage. As a case could be overturned under common law principles if a case manager or legal assessor acted as such in a case in which that person has been involved at the investigation stage we did not consider it necessary to expressly provide that in this Order. Additionally the PSA commented that former and current members of GMC staff should be excluded from sitting on medical practitioner tribunals or interim orders tribunals. We agree that current members of staff should be prohibited and have made an amendment to the order to ensure this however we do not believe it is appropriate to exclude former members of staff where we think there is not the same justification for such a prohibition. The PSA also asked about the ability of the GMC to make rules delegating functions from the MPTS committee to 'officers of the Council'. MPTS staff will be 'officers of the Council' but such officers, undertaking a delegated activity from the MPTS, would be prohibited from engaging in any other function of the GMC. We have also amended the section 60 order to expressly clarify that officers acting for the MPTS cannot be delegated investigation committee functions. We believe that these safeguards do help to achieve the desired effect of separation. The PSA referred to the fact that case managers will be paid by the GMC, but case managers will be performing a statutory office and we have extended the over-riding objective that rules are to secure that cases are dealt with fairly and justly, to the rules relating to their functions.

A further 2% of respondents also did not support the establishment of the MPTS as a statutory committee of the GMC on the basis that the MPTS functioned effectively as a general

committee in any event and the additional protection afforded by 'statutory' status was not required.

10% of respondents did not answer this question.

In view of the responses received, and incorporating the changes discussed above, we consider that establishing the MPTS as a statutory committee is the best way to enhance and protect the separation between the investigation and adjudication roles while retaining the adjudication function with the GMC.

We propose to proceed with this proposal, subject to the modifications stated.

Agree	Disagree	No separation	Want independent body	Use HMCTS	No comment
27%	7%	2%	52%	1%	10%
22	6	2	42	1	8

Q 2: Do you agree that the GMC should not have the power to intervene in the areas falling within MPTS responsibility?

88% of respondents agreed with the principle that the GMC should not have the power to intervene in the areas falling with MPTS responsibility. In line with their answer to question 1, the Authority questioned whether the draft section 60 order will achieve this and we are persuaded, once the amendments discussed in our response to question 1 are incorporated, that this will be assured.

Of the 2% of respondents who disagreed with this proposal, one respondent commented that the GMC should have the power to intervene although did not provide any reasons to support this view. The Royal College of Physicians of England did not support this proposition on the basis of their view that having two bodies may lead to collaborative working resulting in a loss of public confidence. We consider that, while the MPTS and the rest of the GMC are not entirely separate organisations, the division of functions will increase separation between the adjudication stage of fitness to practise proceedings and the GMC's other functions and that the risk of collaborative working will be decreased particularly as the measures are intended to prevent the rest of the GMC from intervening operationally in areas falling within the MPTS responsibility.

10% of respondents did not answer this question.

Two respondents, although supporting the proposal, asked why the GMC should have the power to make rules about how the MPTS is structured and run. The MPTS will be a statutory committee of the GMC and so we consider that at the level of rule-making it is right that it continues to be responsible and accountable. It is also necessary to ensure that the MPTS can be appointed under appropriate conditions and the GMC will need sufficient flexibility in this regard. In order to meet a needs identified by the GMC in this respect we have clarified that the rules may provide that the current members of the GMC's committee may be appointed to the MPTS initially and that the criteria for appointment of MPTS members is to be set and published by the GMC. But the rule making functions relating to the MPTS's and its tribunals' functions will be subject to an overriding objective to secure that cases are dealt with fairly and justly and this will help to ensure that the General Council exercises this role appropriately.

The MDDUS queried why the Chair is an officer of the MPTS and felt that a power for the GMC to delegate tasks and functions to the Chair undermines separation. We can confirm that such delegation would only involve delegation of MPTS functions to the Chair or other officers and that while acting for the MPTS such officers would not be able to act in relation to the rest of the GMC's functions, consistently with the separation of functions from the rest of the GMC. The power to delegate in this way is to enable a proportionate approach to the administration of the MPTS's functions. It is necessary for the Chair to be an officer in order for certain functions to be delegated to the Chair but this does not affect the separation of such functions from the rest of the GMC.

We propose to proceed with this proposal, subject to the modifications referred to above.

Agree	Disagree	No comment
88%	2%	10%
71	2	8

Q 3: Do you agree that the MPTS should keep a record of its members' private interests, and publish this record in the public domain?

89% of respondents agreed with the proposal that the MPTS should keep a record of its members' private interests and publish this record in the public domain. 1% disagreed but did not state why they disagreed and 10% made no comment. We consider that this proposal will help to prevent bias and ensure due propriety.

We propose to proceed with this proposal.

Agree	Disagree	No comment
89%	1%	10%
72	1	8

Q 4: Do you agree that the MPTS should be required to publish an annual report and accounts, to provide a public record and demonstrate accountability?

91% of respondents agreed that the MPTS should be required to publish an annual report and accounts, to provide a public record and demonstrate accountability. Nobody disagreed with this proposal although 9% of respondents did not comment on this question.

The GMC noted that the draft Order does not include a requirement for the MPTS to publish its accounts separately and stated that they would not be able to support such a requirement as it would impact on their arrangements to meet the requirements in relation to accounts under the Charities Act. The MPTS's accounts can be presented as part of the overall GMC accounts, with transparency ensured by also reporting these to Parliament as now, and we consider this will be sufficient. The separation of accounts is not necessary to achieve the separation of functions made by this Order and we consider that the steps necessary to do so would be disproportionate to any benefit.

We propose that there would be a separate annual report for the MPTS and we consider that this proposal will help to ensure that the General Council and the MPTS are brought to account for the effective operation of the MPTS and tribunal functions, including as respects equality and diversity which the provisions expressly require to be addressed in the report.

One respondent also considered that the MPTS should have separate accountability hearings with the MPTS. That decision would be a matter for the Parliamentary Health Committee.

We propose to require the MPTS to publish a separate annual report and that the MPTS's accounts should be incorporated with those of the rest of the GMC.

Agree	Disagree	No comment
91%	0%	9%
74	0	7

Modernising the adjudication procedure

Q 5: Do you agree with the proposal that the over-riding objective of rules relating to fitness to practise procedures should be to secure that cases are dealt with fairly and justly?

There were a range of views in response to this question. While 89% of respondents agreed that the over-riding objective of rules relating to fitness to practise procedures should be to secure that cases are dealt with fairly and justly, a number of respondents raised further issues. Several of these respondents noted that the over-riding objective in the draft order only applied to the making of the procedural rules rather than their interpretation and application and considered that the latter is equally important. We agree that the application of the rules is important although, following the example of the Tribunal Service Rules and the Civil Procedure Rules, believe that a requirement to apply the rules so as to secure that cases are dealt with fairly and justly should be set out in the rules themselves. The intention is that the GMC will do this when they make their relevant rules. This point also caused us to revisit our provisions to ensure that the over-riding objective applies to the making of all relevant rules. We have as a result amended the order so that it applies to all the rule making powers which govern MPTS hearing procedures, incorporating also the rules that will govern the constitution of the MPTS, medical practitioners tribunals and interim orders tribunal and the rules relating to case managers and legal assessors.

One respondent asked how the over-riding objective interacted with the duty to have regard to the overarching objective. The purpose of the over-riding objective is to ensure that the procedures are fair and just, while the duty to have regard to the over-arching objective indicates to fitness to practise panels those factors to which they must take into account in determining the substantive questions of impairment and sanction. The over-riding objective in the making of rules is to secure that those cases are dealt with fairly and justly will still apply. Further, the draft section 60 Order makes clear that where the GMC consider, when making the relevant rules, that there is a conflict between meeting the two objectives, that they must give priority to the over-riding objective.

The PSA noted that the rules will need to be compliant with European Convention on Human Rights in any event and that an explicit over-riding objective of justice and fairness was unnecessary. However, we consider there is nevertheless an advantage to express provision and also taking into account that this is the approach adopted in Her Majesty's Courts and Tribunals Service, we are persuaded of its merit.

Two respondents including the Royal College of Obstetricians and Gynaecologists said that the impact of the fitness to practise procedures should be considered and that the over-riding objective should be contextualised by specifying the need to cause least disruption to the parties involved (including considering the impact on the registrant's family and service provision) and to be resolved in a timely and cost effective way. While acknowledging that those principles may have a place in helping to secure that cases are dealt with fairly and justly, we would not want them to be given priority over other factors that also further the aims of fairness and justice where the circumstances do not warrant that. We think that it is better to have a simple test which enables the right weight to be given to relevant matters as appropriate so as to achieve an over-riding objective of securing that cases are dealt with fairly and justly.

9% of respondents did not comment on this question.

We propose to proceed with this proposal, subject to the modifications stated.

Agree	Disagree	No comment
89%	2%	9%
72	2	7

Q 6: Do you agree that to enhance the pre-hearing case management arrangements, we should enable the MPTS to appoint case managers, including using the chair of a medical practitioner tribunal (where legally qualified) as case manager?

65% of respondents agreed that the MPTS should be able to appoint case managers. They also supported the proposal of enabling a chair of a fitness to practise panel, where legally qualified, to act as the pre-hearing case manager.

A further 6% of respondents supported the principle of the MPTS appointing case managers but raised concerns about the potential use of legally qualified panel chairs undertaking the role and a further 16% of respondents were firmly opposed to the use of legally qualified chairs in this way. Concerns included:

- The risk of the panel chair's opinion having undue weight with the rest of the panel as they would be more familiar with the case.
- The risk that the panel chair may be prejudiced by the evidence they had seen at the pre-hearing stage or it might create a conflict of interests.
- That a move towards legally qualified chairs would exclude the potential for medically qualified chairs which may be appropriate depending on the case.
- That 'legalising' the process may in fact slow the process down.

As pre-hearing case management directions deal with procedural, administrative and organisational matters, we are not persuaded that this on its own would give the panel chair's opinion undue weight in relation to the substantive decisions but it would allow the chair to manage the hearing itself more robustly and efficiently. However we recognise that there may be some issues which the chair, acting as the case manager, may consider needs to be decided by the panel as a whole to ensure that a just and fair decision is reached. We have amended the draft section 60 Order to make it clear it also enables a panel as a whole to conduct its own case management. In addition the case manager (whether a legally qualified chair of the panel itself or otherwise) is able to convene the whole panel for a preliminary hearing and case management issues could be considered at such a hearing. This flexibility will ensure that the full panel can be involved where it needs to be

In the circumstance that a panel chair undertaking case management was exposed to evidence which could prejudice them in the final hearing, we are confident that that case manager would recuse themselves from the role of chairing the panel where required in accordance with common law principles in order to avoid rendering the decision challengeable.

As regards the objection raised to only allowing legally qualified chairs to act as case managers, apart from persons appointed only as case managers, we consider that legal training does provide an advantage in terms of case management skills and it is common in other jurisdictions for case managers to be legally qualified for this reason. Further just because the only class of chairs that can act as case managers are legally qualified chairs does not mean that other chairs will not be appointed. The choice of chair is a separate decision and there would still be a

power to appoint a legally qualified, medical or lay chair as may be required and it would be an operational decision for the MPTS to appoint the most appropriate chair for the individual circumstances of a case.

We do not agree that enabling a legally qualified chair to also act as case manager runs the risk of slowing down the process. This is standard practice in Her Majesty's Courts and Tribunal Service and the General Pharmaceutical Council have been operating this model successfully for a number of years.

The Medical Protection Society (MPS) also raised an issue that there is no criteria for who may be appointed as a 'legally qualified chair'. We intend that the criteria for appointment as a case manager will be set and published by the MPTS and any chair would need to satisfy the same criteria. We have made an amendment to clarify the need for the chair to satisfy the same criteria as to legal qualifications and experience as other case managers.

We consider that the MPTS will be in the best position to determine the criteria so that case managers will be able to effectively perform their functions. The MPS suggested that an alternative would be for the legal assessor appointed to the case to also be appointed as the case manager. However we consider it would be better to keep these roles separate.

A further 5% of respondents were either neutral as to the proposal or unsure of the benefits and 8% of respondents made no comment.

We propose to proceed with this proposal, subject to the modifications stated.

Agree	Agree (except that Legally Qualified Chairs should undertake case management)	Neutral	Disagree	Unsure	No comment
65%	6%	4%	16%	1%	8%
53	5	3	13	1	7

Q 7: Do you agree that the MPTS should have power to appoint legal assessors where it considers it appropriate to do so?

22% of respondents agreed with the proposal. This group included the NMC who also expressed the view that there are situations where it is neither necessary nor proportionate to have a legal assessor in attendance. One of these respondents stressed the need to ensure that the process for appointing legal assessors to panels needed to avoid creating any conflicts of interests. We agree with this point and consider that if a legal assessor did find that they had a conflict of interest they would be under a professional duty to recuse themselves. A further 6% identified benefits and cautiously welcomed the proposal but made the point that the evolving roles of legally qualified chairs would need to be carefully monitored.

The remainder of the respondents included the group of 39 co-ordinated responses, who did not give reasons. Those who gave reasons raised concerns about the impact of removing legal assessors from hearings including:

- That is an unnecessary cost cutting measure.

- That the legal assessors serve a critical role, particularly in cases involving an unrepresented doctor, in ensuring that the doctor understood the procedures and providing impartial advice on points of law.
- That a legal assessor should be available if either of the parties requested one.
- That a legally qualified chair may find it difficult to perform all of the functions of a chair and a legal assessor.
- That legally qualified chairs will “legalise” the proceedings and could lead to conflict between the chair and other tribunal members.

We have borne in mind that the role of a legal assessor is to provide advice to the panel on issues within the legal assessors functions such as points of law and procedure. But it is not to act as an adviser to any particular party or to run the hearing. However we agree that there are factors which might indicate that having a legal assessor would enable the hearing to run more smoothly (for example if a doctor were unrepresented or the case particularly complex). As a result we intend this power to be flexible enough to enable the MPTS to appoint a legal assessor where the circumstances of the case indicate to it that this is appropriate.

We are not satisfied that a legally qualified chair will not be able to cover matters falling within the scope of a legal assessor’s functions. Many courts and tribunals with legally qualified members, including tribunals dealing frequently with unrepresented parties, do not also have a legal assessor. But we are persuaded that unless the chair of the tribunal is legally qualified a legal assessor will always be required and we have amended the section 60 Order to provide for this and clarified that such a chair must have the same legal qualifications and experience as a legal assessor. By these means we intend to ensure that the tribunal can be provided with advice on the same matters that are within the scope of a legal assessor’s functions. In addition, we have also made a further amendment to enable rules to include a requirement that the parties are informed of any advice given by a legally qualified chair falling within the scope of a legal assessor’s functions, to ensure transparency in the same way as for legal assessors.

As regards concern about legalising the proceedings, whether there is a legal assessor, legally qualified chair or both present, the aim will always to be ensure the proceedings are conducted in accordance with the law with the help of a suitably qualified lawyer. The tribunal members will need to take into account such advice whether it is from a legal assessor or from the chair and we consider that the tribunal members will be able to follow any advice as necessary to ensure the right outcome whether it is from the chair or legal assessor.

6% of respondents did not comment on this question.

We propose to proceed with this proposal, subject to the modifications stated.

Agree	Cautiously agree	Disagree	No comment
22%	6%	65%	6%
18	5	53	5

Q 8: Do you agree with the proposal that the MPTS should have power to award costs, draw adverse inferences and refuse to admit evidence following a party's failure to comply with rules or directions or otherwise award costs for unreasonable behaviour?

73% of respondents supported the proposal to enable the MPTS to award costs, draw adverse inferences and refuse to admit evidence following a party's failure to comply with rules or directions or otherwise award costs for unreasonable behaviour.

Three respondents agreed with part of the proposal. One of these felt that the MPTS should not have the power to award costs or draw adverse inferences and another felt that these powers should reside with the GMC rather than the MPTS. The Medical Protection Society agreed that having a power to award costs would support effective case management where an unreasonable failure to comply with a rule or direction had led to an adjournment or postponement of a hearing however did not agree with powers to exclude evidence or draw adverse inferences as they considered this could be potentially unjust.

8% of respondents disagreed with the proposal arguing that the power to award costs does not sit comfortably in the regulatory jurisdiction which is not intended to be punitive and that it could lead to costly satellite litigation. The Medical and Dental Defence Union of Scotland (MDDUS) stated that they did not think it was appropriate to penalise doctors by awarding costs, drawing and adverse inference or refusing to admit evidence because they had failed to meet an arbitrary case management timeline. They were concerned as to potential for infringement of rights under the European Convention on Human Rights. In the case of costs orders, the MDDUS raised a concern that, without the benefit of legal experience, a panel may make arbitrary costs orders. The power to award costs will be subject to rules which will also need to be made in accordance with the over-riding objective to be just and fair. The GMC will need to ensure that any rules enabling a costs regime are applied in accordance with that principle.

One respondent said that if these powers were employed against the GMC it could create the potential for a panel to exclude evidence submitted by the GMC with the result that a finding of impairment was not made. We would however expect the GMC to conduct the proceedings so as to avoid this.

A further respondent stated that the GMC as well as persons who make unfounded complaints should be liable for the award of costs as well. The order does allow for the GMC to be liable for costs in the event of unreasonable behaviour although this is also likely to be a rare event. This power cannot be extended to cover persons who make an allegation but subsequently frustrate the progress of a case as they are not parties to the proceedings. It is rather the GMC's responsibility to manage any witnesses they wish to provide evidence.

5% of respondents felt there was insufficient detail in the proposal and a further 10% did not comment on this question.

The tribunal would only be able to exercise these powers where rules have provided for them and it would be fair and just to do so and compatible with human rights. Such powers are not unprecedented and where they are used, by courts, tribunals and other regulatory jurisdictions, it is well established that their use should respect those principles. If they were exercised in circumstances where that was not the case the parties concerned could seek to challenge this on appeal in the higher courts. The relevant rules will be made in accordance with the over-riding objective of securing that cases are dealt with fairly and justly. We

consider that it is appropriate for the tribunals to have these powers to help manage the conduct of the parties and ensure effective proceedings which further the aim of public protection. While awards of costs may themselves be subject to litigation, we consider that their use will nevertheless offer a proportionate means of seeking to ensure fair and effective proceedings.

The GMC will need to consult further on the procedural rules which govern the awarding of costs, adverse inferences and refusal to admit evidence which as stated above will need to reflect the over-riding objective of securing that cases are dealt with fairly and justly.

We propose to proceed with this proposal.

Agree	Agree in part	Insufficient detail	Disagree	No comment
73%	4%	5%	8%	10%
59	3	4	7	8

Q 9: Do you agree with the proposal to enable reviews to be held by the tribunal chair without the need for a panel hearing when the GMC and doctor are in agreement, subject to the ability of the chair to nevertheless convene a full hearing?

81% of respondents supported the proposal to enable orders to be reviewed by a panel chair without the need for a hearing where the GMC and the doctor were able to agree on the appropriate outcome. One of these respondents commented that chairs would need clear guidance on what circumstances might require them to convene a full panel. We agree that the MPTS should provide training and guidance in this regard and this will be a matter for the MPTS going forward.

7% of respondents felt that this process lacked transparency and that public confidence may be undermined if the decision were not taken by a full panel or that doctor may agree to an outcome to avoid exposing themselves to additional costs. Some respondents also commented that there may be certain complex cases which should properly be considered by the panel rather than the chair acting alone.

Of the remaining two respondents, one felt it was appropriate only for interim orders reviews which could be dealt with more expeditiously. Conversely the other respondent felt that it would not be appropriate in interim order reviews because the panel may well disagree with both the GMC and the doctor regarding the appropriate outcome. We think there is value in the expedition which reviews on papers will enable in full matters as well as interim ones if a chair or tribunal do not agree with the proposed outcome, they will be able to convene a hearing.

9% of respondents did not comment on this question.

Any decisions made by a chair reviewing a case will be subject to the same publication and disclosure requirements as existing review hearings. We consider that this will ensure a proportionate level of transparency.

As respects concerns that a doctor may agree to a review on the papers in order to save costs, the doctor should not agree to a different outcome in order to have a review on the papers. Matters of professional registration are serious and we do not consider that costs

considerations would ordinarily exert the level of pressure so as to lead doctors to disregard those greater concerns and compromise their view as to the correct outcome in relation to their registration position to enable an agreed outcome with reduced costs through a review on the papers. The GMC have committed to ensuring that information will be delivered in accessible formats and that there is sufficient time with the process to enable a doctor to discuss it with an adviser. If a particular doctor were to agree to a different outcome to save costs through a review on the papers, that would be a matter of subjective priority for the doctor but we do not think that providing scope for a doctor to agree a review outcome and that this can be dealt with by a review on the papers should in itself lead to that result. There will be additional safeguards that if the chair or tribunal considering the agreed outcome believe it is potentially too severe or otherwise wrong they would be able to convene a hearing to consider the matter further. Accordingly we believe that any potential disadvantages can be avoided.

There are notable advantages. In addition to the advantages of speed of process and proportionality through enabling matters to be resolved by consent and not require a hearing, the nature of GMC hearings, being like a court room, are anxiety provoking so enabling review hearings by consent should reduce the stress for all concerned, including doctors and witnesses. However we do agree that there may be cases which are extremely complex and would benefit from review by a full panel rather than by a chair acting alone. As a result we have amended the section 60 order to enable such reviews to be conducted by a chair acting alone or a panel according to the circumstances of the case.

We propose to proceed with this proposal, subject to the amendments stated.

Agree	Agree in interim orders cases	Agree but not in interim orders cases	Disagree	No comment
81%	1%	1%	7%	9%
66	1	1	6	7

Q 10: In order to improve efficiency do you agree that the GMC should be able to provide notification of decisions by email rather than letter, when an email address has been provided for this reason?

27% of respondents agreed that it would improve the speed of communication if notifications of decision could be provided by e-mail. A further 7% agreed if further safeguards could be introduced to ensure that critical information was not lost. However a large proportion of respondents (57%) felt that there was a high risk associated with e-mail delivery and that there needed to be confirmation of receipt and/or an alternative hard-copy notification as well.

While we think the risk is low given that the GMC and MPTS would only be able to use such an e-mail address where it has been specifically provided for the purpose, to minimise the risk, we have now amended the order so that proof of service provisions require that a 'read receipt' has been obtained for any notifications sent by e-mail to confirm they had been seen and opened. In the absence of any such 'read receipt', service would not be effective and a hard copy would need to be served as now. We consider that the requirement for a 'read

receipt' would provide the necessary additional protection and that it is not necessary to require service by hard copy in such cases as well.

We propose to proceed with this proposal, subject to the amendments stated.

Agree	Agree (with further safeguards)	Disagree	No comment
27%	7%	57%	9%
22	6	46	7

Enhancing confidence and accountability

Q 11: Do you agree that the over-arching objective of the protection of the public, which involves the objectives of protecting, promoting and maintaining the health, safety and well-being of the public, promoting and maintaining public confidence in the profession and promoting and maintaining proper standards and conduct for members of that profession, should be the over-arching objective of the GMC and that medical practitioner tribunals and interim orders tribunals should have regard to it when making their decisions?

75% of respondents agreed that the GMC's overarching objective should be the protection of the public. The NMC considered this approach simply codified the existing position in case law and should not give rise to any significant change of approach for panels and considered the same approach should be taken for all the health care regulators. However, the group of 39 co-ordinated responses were within this group of respondents and they did not support including the element of 'promoting and maintaining public confidence in the profession' as part of that wider over-arching objective, although only one gave a reason: that confidence in the profession is high despite the GMC and not because of it and so that element should be dropped. Accordingly it would appear that that individual was not taking issue with the importance of maintaining public confidence in the profession but did not believe that the GMC would be able to help to achieve this. This may have been a concern for some or all of the rest of the co-ordinated group. General concerns about the GMC expressed by the co-ordinated group of 39 responses are addressed at question 24. For the purposes of this proposal, the government does not consider that the GMC would not be able to successfully pursue or have regard to such an objective. One respondent also considered that the objective should be binding on all concerned and not a duty to have regard. We propose that it is expressed as a duty to have regard in the case of medical practitioners tribunals as they will be acting in a quasi-judicial role and have other considerations to take into account, including the over-riding objective, and will need to be able to weigh these up also.

16% of respondents disagreed with the proposal. Some respondents argued that fitness to practise panels (and in the future medical practitioner tribunals) are already required to have regard to the three elements of protecting, promoting and maintaining the health, safety and well-being of the public, promoting and maintaining public confidence in the profession and promoting and maintaining proper standards and conduct for members of that profession. Others in this group argued that placing public confidence in the profession on an equal footing with the other two factors risked creating a more punitive system of medical regulation. Some argued that it is inconsistent with a tribunal's duty to consider all the facts or the over-riding objective. Some also argued that the over-arching objective was beyond the scope of the reforms which are otherwise in relation to the GMC's adjudication function and one argued that existing case law principles reflected by the over-arching objective do not apply outside fitness to practise.

The PSA said that the wording of 'promoting and maintaining proper standards' was a departure from the case law which had used the phrase 'declaring and upholding standards' and questioned its appropriateness for the MPTS.

A solicitors firm felt that the development of the overarching objective should be taken forward in the wider context of the Law Commissions' review of the regulation of healthcare professionals rather than for one profession only in a section 60 order. While this section 60

only addresses the objectives of the GMC, a private members Bill currently before Parliament — the Health and Social Care (Safety and Quality) Bill — which is supported by the government would, if enacted, make similar provisions for the other regulators of health and, in England, social care professionals (except the Pharmaceutical Society of Northern Ireland).

Two respondents also questioned whether it was appropriate to apply the duty to have regard to the over-arching objective to the interim orders process. We have considered whether it is appropriate to apply the duty to have regard to the over-arching objective to interim orders tribunal and have reached the conclusion that there is already a very specific statutory test which interim orders panels (and in the future interim orders tribunals) will have to apply in considering whether to impose an interim order and that a duty to have regard to the over-arching objective will not add any assistance in that case. In particular section 41A requires that an interim order can only be imposed where it is necessary for the protection of members of the public, or is otherwise in the public interest, or is in the interests of a fully registered person. As a result we do not think that the application of the duty to have regard to the overarching objective is required in addition to this existing criteria and have removed this from the section 60 order. Alongside this change and informed by the views of the GMC and NMC we have confirmed that in addition to medical practitioners tribunals the duty to have regard to the over-arching objective is to apply to decisions within the investigation committee's remit which relate to a final disposal involving the imposition of a warning or the agreement of an undertaking.

We consider that maintaining public confidence is an important part of the over-arching objective and we do not agree that it will make medical regulation more punitive. Describing public protection as the 'overarching' objective which involves the pursuance of the objectives to protect, promote and maintain the health, safety and well-being of the public; public confidence in the profession and to promote and maintain proper professional standards and conduct for members of that profession achieves the policy intention of ensuring that public protection in its fullest sense is central to everything that the regulators do. The three specific elements are only relevant in so far as they further the overarching objective of public protection. They do not impose new functions on the GMC but confirm the aims behind the exercise of those functions. Including the element of promoting and maintaining public confidence is important and should be considered in this context where it has an impact on public protection. For example if the actions of a doctor appear likely to reduce confidence in the medical profession and influence the decision of individuals as to whether to seek medical help at all, it may be right to take action in relation to that doctor's fitness to practise. It should be noted that those tasked with considering whether public confidence in the profession will be affected are being asked to make an objective judgement of their own as to whether particular acts or omissions would affect public confidence if not action were taken rather than to seek out the views of the public or the media as to what they think should be done. They will have to do this after consideration of all the relevant facts. The relevance of public confidence in the profession or the reputation in the profession as a basis for fitness to practise action is established in case law and its express inclusion in the over-arching objective will help to ensure it is given due weight in all cases. Equally the aim of upholding standards is reflected in case law.

We consider it is important that the overarching objective will ensure that the GMC will act across the range of its functions with a focus on public protection, including issues that would affect public confidence in the profession or proper professional standards and conduct. For instance standards and guidance will also need to reflect these objectives. If

the objective were limited to fitness to practise matters, other aspects of the GMC's functions would not also have the same new improved objectives and the reform would be incomplete.

With reference to the PSA's objections, we remain of the view that 'promoting and maintaining' is the appropriate formulation. The objectives clarify the aims behind the exercise of existing functions, do not create a new function in themselves and are involved in an over-arching objective of public protection so they should be seen in that context. The choice of 'promoting' is consistent with the language recommended by the Law Commissions which aims to use consistent wording for all three elements and suitably includes the imperative to advance or improve, rather than just declare, uphold or maintain. In our view it is right, given that context, that the GMC's role in the exercise of its functions in relation to fitness to practise matters includes advancing and improving public confidence in the profession so that individuals feel safe to go and see a doctor. If it were to only maintain confidence, the implication would be that the status quo in terms of public confidence must always be good enough and that may not always be the case, such as where there have been particularly notorious acts by a doctor which have damaged the reputation of the profession for a period of time. Equally the MPTS should have objectives consistent with this for the same reasons, although in its case this should also be viewed alongside the over-riding objective of the rules under which it operates of securing that cases are dealt with fairly and justly and that in making such rules the GMC is to ensure that the over-riding objective is given priority if there is any conflict.

9% of respondents did not comment on this question.

5% of respondents considered that in the case of the MPTS and its tribunals the over-riding objective should have priority over the over-arching objective. Our provisions confirm that when making the relevant rules, if there is a conflict, the over-riding objective is to be given priority. As stated above the rules will provide that in their operation of those rules the tribunals will similarly have the aim of securing that cases are dealt with fairly and justly, and so that should be given priority if there is any conflict with their duty to have regard to the over-arching objective.

While arguing for the current objective to remain, two respondents argued that the GMC should consider the impact of its functions on the health and safety of practitioners and their families. While the over-arching objective will be public protection, the GMC will be able to pursue that in a proportionate manner with regard to the impact of its actions, even though public protection will of course require that it does take action where necessary.

We propose to proceed with this proposal, subject to the amendments stated.

Agree	Disagree	No comment
75%	16%	9%
61	15	7

Q 12: Do you agree that we should require registration appeals panels to have a duty to have regard to the over-arching objective in the same way that a medical practitioners tribunal should have to?

Although there was similar support expressed (as well as similar reservations about including 'maintaining public confidence') for extending the duty to have regard to the over-arching objective to registration appeals panels, the GMC have questioned whether there is

a need to do so given that registration appeals panels do not have the same role in relation to determining questions of fitness to practise and any sanctions arising, which is where the duty to have regard to the over-arching objective is intended to be brought to bear, but are looking at issues which are determined by different questions. We agree that a duty to have regard to the over-arching objective is not necessary in their case and have removed these provisions from the section 60 order.

While more relevant to the previous question, within their response to this question one respondent also asked how the duty to have regard to the over-arching objective fitted with the application of the civil standard of proof. The civil standard of proof will still apply to finding of facts in a fitness to practise hearing. That, is based on the evidence before it, on the balance of probabilities, whether facts are found by the medical practitioners tribunal to be proven. Having made findings as to the facts, the medical practitioners tribunal goes on to decide the question of whether they support a ground of impairment (e.g. misconduct) and if so whether that amounts to impaired fitness to practise and what, if any, sanction is appropriate. The duty to have regard to the overarching objective will be relevant to the question of impairment and sanctions and what facts need to be proved to support those but it will not alter the application of the civil standard of proof.

We do not propose to proceed with this proposal.

Agree	Disagree	No comment
82%	9%	9%
67	7	7

Q 13: Do you agree with the proposal that the GMC should have a right of appeal, corresponding to the PSA’s power to refer cases, to the higher courts in order to challenge MPTS decisions?

The majority of consultation respondents (70%) did not agree that the GMC should have a right of appeal corresponding to the PSA’s power to refer cases to the higher courts in order to challenge MPTS decisions. This included the group of 39 co-ordinated responses, although they did not give reasons. A number of respondents felt that the PSA were the appropriate independent body to review MPTS decisions while others felt that it could undermine the MPTS if the GMC were appealing its decisions. Concerns were also raised about the potential for cases to be reopened where they otherwise would not be or double jeopardy if both the GMC had a right of appeal and the PSA had a power to refer cases to the relevant higher court.

17% of respondents supported the proposal while a further 4% were unsure. One respondent also commented that the PSA’s power of reference should extend into the investigation stage of the GMC’s fitness to practise procedures. 9% of respondents did not comment on this question.

Providing a right of appeal for the GMC to challenge MPTS decisions has been a long term objective that was part of the proposals surrounding the establishment of OHPA and was originally legislated for in 2008 alongside that (although repealed alongside the abolition of OHPA). We remain confident that introducing a right of appeal for the GMC is appropriate given the increased separation between the investigation and adjudication functions and the status of the GMC as one of the parties at a medical practitioners tribunal hearing. The policy intention, once separation of functions has been achieved, is to enable the

organisation best placed to challenge a tribunal decision about a doctor's fitness to practise to be able to do so where it is considered that the outcome does not sufficiently protect the public. The GMC, having already acted in the prosecution role before the tribunal is likely in the future to be better able to make such a challenge given its closer knowledge of the case. Additionally the Parliamentary Health Committee¹ has recommended that a right of appeal for the GMC should be introduced. We do not consider this will undermine the MPTS but reflects and underlines the increased separation between it and the GMC's prosecution role.

Concerns about double jeopardy have been considered by the courts in relation to the PSA's existing power of reference to the higher courts. In the case of *Council for the Regulation of Healthcare Professionals v General Medical Council and another, Council for the Regulation of Healthcare Professionals v Nursing and Midwifery Council and another* [2004] EWCA Civ 1356, the Court of Appeal confirmed that they do not find it surprising that considerations of double jeopardy should take second place to the protection of the public. While not commenting on other aspects of the judgment, we agree with that principle. Under the proposed new mechanism the PSA will not be able to take separate proceedings once the GMC has commenced an appeal, although they will be able to become a party and make representations in a GMC appeal in cases where they consider there is insufficient protection of the public. The GMC will equally be able to make such representations in a PSA reference, where they will be a statutory respondent. If the GMC withdraws an appeal, if the PSA are not satisfied that the public will be sufficiently protected they will be able to continue the proceedings on their own account. There will be mirror image powers for the GMC in a PSA reference. The grounds for a GMC appeal and any PSA reference will be whether there is sufficient protection of the public. Accordingly protection of the public will continue to be the objective of these proceedings and we consider that the proposal is a proportionate means of pursuing a legitimate aim.

Concerns were also raised about increased costs for the MPTS of defending appeals and as to costs for the practitioner. We can confirm that the MPTS will not need to be a party to the appeal so will not incur costs in that respect. In respect of the costs of the other parties we expect the court to make reasonable orders as to costs in the particular circumstances of each case.

The PSA also queried how the GMC could take an appeal against a decision made by a medical practitioner tribunal given that the MPTS will be part of the GMC. However we do not see any problem with this given that the tribunal is intended to be operating independently. Also the MPTS will not be a respondent in the event of a GMC appeal. The GMC as a party to the appeal will be seeking to challenge the outcome where it considers its grounds for appeal are met. The other party, the practitioner, already has a right of appeal although it is not subject to the same express grounds.

The PSA have also raised the issue as to what happens if the GMC abandon grounds or withdraw the appeal and raised a concern that they would need to become a party to every appeal in case the GMC withdrew or abandoned grounds and suggested that instead they be listed as an automatic respondent in every case. As discussed above, the policy intent is to ensure that the organisation best placed to challenge a tribunal decision about a doctor's

¹ See Health Committee - First Special Report 2013 accountability hearing with the General Medical Council: Tenth Report of Session 2013-14, HC 897 and Health Committee — 2012 accountability hearing with the General Medical Council: Fourth report of Session 2012, HC 566

fitness to practise to be able to do so where it is considered that the outcome does not sufficiently protect the public and ordinarily we would expect the GMC to pursue its own appeals diligently and to not give up points without good reason. We have made provision for the PSA to be able to take over the case if they think that the GMC propose to withdraw where it should not and in light of the PSA's views we have now provided a process to enable them to do this even where they are not already a party so that they do not have to become involved beforehand just to ensure they can do so. As respects abandoned grounds we have adjusted the provisions which were intended to enable the PSA to make representations to make clear that it can become a party but not have to make representations unless it considers it necessary to do so in order that, where it considers it appropriate in a particular case, it only need make representations if grounds are abandoned which it thinks should not be. By these means we have made it easier for them to pick up abandoned grounds in such cases. But we do not agree that the PSA should be automatically made a respondent.

The PSA asked what would happen in the circumstance that both the registrant and the GMC make an appeal at the same time. Cross appeals of this nature are not unheard of and we do not consider the courts will have any difficulty managing this.

The PSA also raised the issue as to the time limit for them to make a decision whether to make a reference to the relevant higher court which is currently based on 40 days following the 28-day period that the registrant has to make an appeal or, where the registrant does not have an appeal, 40 days from notification to the registrant of the decision. In the circumstances where the registrant has no right of appeal (for example because no order has been made), the PSA have suggested confirming that the PSA has 56 days so that it has 28 days in which to decide whether to appeal after the expiry of the GMC's 28-day period. We consider that this is proportionate, particularly as it would still be less than the time it has for making a referral where the registrant also has a right of appeal, and we have amended the draft accordingly. We have also included a requirement for the MPTS to serve the Registrar and the PSA with their decisions so that there is certainty that they will receive the necessary decision when it is served on the practitioner.

We propose to proceed with this proposal, subject to the amendments stated.

Agree	Disagree	Unsure	No comment
17%	70%	4%	9%
14	57	3	7

Q14: Do you agree that we should amend the grounds of the PSA's power to refer fitness to practise cases for consideration by the relevant court for all regulated healthcare professions and social workers in England in the manner described and also reflect those grounds in the GMC's new right of appeal?

24% supported the proposal to amend the ground of the PSA's power to refer fitness to practise cases for consideration and to reflect those grounds in the GMC's new right of appeal however the majority (63%) did not support the change. This group included the group of 39 co-ordinated responses but they did not give reasons. Some objected to the inclusion of the element relating to maintaining public confidence for the same reasons as expressed in responses to question 13. Others preferred the status quo as they consider it to be narrower, did not consider that the case for change had been made out and

considered that the revised grounds will make it easier to for the PSA to intervene where it does not agree with the tribunal outcome. Some gave reasons that indicated that their main objection was to the proposals for the GMC to have an appeal right which is already discussed at question 13.

The PSA did not consider that we had made the case for a change but referred to legal advice which they had obtained on the proposed revised grounds which concluded that the changes were a welcome simplification but were unlikely to lead to an increase in the number or type of cases referred.

We agree that the proposed revised grounds are a welcome simplification. It will expressly refer to each of the three elements contained within the over-arching objective discussed in relation to question 11. Case law has already established that the broad principles which these three elements are designed to capture (public protection, upholding standards and maintaining public confidence in the profession) are applicable in fitness to practise matters and appeals or referrals to the high court but we consider there are advantages to expressly stating them, using the slightly modified language used in the objectives, as this will ensure they are given due weight in every case. The grounds for appeal or reference will require the GMC or PSA to be satisfied that the tribunal outcome does not achieve sufficient public protection (including all three specified elements) and we are satisfied that is an appropriate benchmark and clearer and more transparent than the existing requirements to show undue leniency and that the reference is desirable for the protection of the public. If the GMC or PSA consider the outcome is insufficient to achieve public protection we would want them to be able to seek to redress that. While we do not expect that this change is such that it will in itself lead to a substantial increase in the number of cases that may be brought we do consider that it will enable greater confidence when deciding which cases should be taken forward to the higher courts to ensure public protection and also provide greater clarity for the parties and the courts when considering if the grounds are made out.

We propose to proceed with this proposal.

Agree	Disagree	Unsure	No comment
24%	63%	3%	10%
20	52	2	8

Q 15: Do you agree that the GMC should be able to request, in writing, information or documents to assist with the investigation of allegations, and where such a request has been made the registrant fails to comply, the GMC should be able to refer the case to a medical practitioner tribunal?

There was strong support for this proposal (74%) amongst respondents although a number of these respondents said that powers to suspend a doctor where they have failed to comply should only be exercised in exceptional circumstances.

A further 10% of respondents said that it would depend on how this power were used and the scope of the information being requested, and would want its use to be reasonable and relevant to an investigation and to respect the privilege against self-incrimination. One of these respondents questioned whether it would be appropriate to use this power if the doctor were suffering from a mental health illness. One respondent thought that it would increase the workload of the MPTS significantly. A number suggested guidance as to its use.

7% of respondents did not feel that that this power was appropriate as it would impinge on a person's right not to self-incriminate themselves. One argued it should be subject to a reasonableness requirement. Two respondents suggested that it would reverse the burden of proof. One considered that it would be preferable to enable the GMC to apply to the court for an order for disclosure so that it could rule on whether disclosure should be required. One questioned whether the case for change was made out.

We do not agree that the power could be used to interfere with the right of persons to not self-incriminate themselves. The provision will become subject to the existing provisions of section 35A of the Medical Act 1983 which expressly exclude information which a court could not be compelled to be produced in civil proceedings or that would be prohibited by or under any enactment. This ensures the privilege against self-incrimination is maintained.

One respondent asked how could be it be fair or just for a doctor, who was not the respondent doctor, to be subject to such a severe sanction. The power to require information or documents from someone who is not the subject of the investigation is already available, however the potential sanctions for non-compliance would not apply in that case as it will only apply to doctors whose fitness to practise was under investigation.

A solicitors firm and the Medical Defence Union (MDU) also raised the point that such a request could potentially bypass a third party's right to confidentiality. However, the safeguards referred to above that exclude information or documents which a court could not compel to be produced in civil proceedings or that would be prohibited by or under any enactment should also prevent the bypassing of third party rights to confidentiality under statute or civil law.

The power is limited to the purposes of requiring the provision of information or documents (other than excepted information of the nature described) in respect of fitness to practise of the person concern or to investigate whether a person is temporarily registered. Accordingly, its use should only be reasonable and relevant for such purposes. If this could not be compelled a registrant would be able to impede the investigation into their fitness to practise by not co-operating with requests for the production of the information or documents, with a consequential impact on public protection.

Where a case is referred to a tribunal to consider a sanction for non-compliance the registrant will have the opportunity to be heard. By these means they will be able to explain if they think that they have complied or if they think there are good reasons as to why they have not done so or why they should not be subject to sanctions. It will be possible for the tribunal to consider matters such as mental illness. The tribunal will be required to have regard to the over-arching objective of public protection and they will need to exercise their discretion consistently with that duty. They will be operating under rules which will be subject to the over-riding objective to secure that cases are dealt with fairly and justly. There will be a right of appeal to the higher courts, which will be able to give a ruling on whether a disclosure should be required if necessary, and any sanction will not take effect while the appeal is pending. If after a sanction is imposed but before it has expired the registrant subsequently provides the information or document a review can be carried out and the registrant could seek to have the sanction revoked.

We do not accept that it will reverse the burden of proof. It is only a means of obtaining relevant information and documents, subject to appropriate controls and constraints.

The GMC have considered this proposal and have not raised any concerns about impact on the MPTS's workload. They consider that it will assist them in meeting their statutory objectives and allow them to address non-compliance with investigations which can result in investigations becoming protracted and increase risks to the public.

We consider that any impact will be in proportion to the benefit in terms of public protection and that this proposal is a proportionate means of achieving that legitimate aim.

A further 9% did not comment on this question.

We propose to proceed with this proposal.

Agree	Depends	Disagree	No comment
74%	10%	7%	9%
60	8	6	7

Q 16: Do you agree that where a doctor fails to engage or comply with a direction to undergo a performance, health or language assessment, the GMC should be able to refer the case to a medical practitioner tribunal to consider a suspension order or conditional registration?

30% of respondents supported the proposal to have a consistent approach towards a failure to comply with performance, health and language assessments.

However the majority of respondents (58%) did not support these proposals. Only a small number of these respondents commented as to why they did not support these proposals. The group of 39 co-ordinated responses did not give reasons. Of those that did give reasons, a number felt that the fitness to practise rules already deal with these issues and preferred the express reference in those rules to the decision to impose an assessment or its requirements having to be reasonable. Another respondent felt that the onus was on the GMC to prove that a registrant was impaired and simply failing to comply with an assessment was not adequate.

A small number of respondents (4%) raised concerns about how these provisions applied in health cases and one respondent suggested that these matters may be better considered by an interim orders tribunal. A further 8% of respondents did not comment on this question.

The GMC already have rules enabling a referral to a fitness to practise panel for possible suspension or conditions in the event that a doctor fails to comply with the reasonable requirements of an assessment team. These provisions would add that a failure to submit to an assessment at all would also be subject to the similar sanctions. The proposed new provisions will also confirm that an initial suspension is subject to a maximum of 1 year and conditions are to be subject to maximum of 3 years (it is possible that either of these could be replaced, varied or extended on review but they cannot be replaced with a direction for erasure). The proposals would therefore refine them and set them out on the face of the Act, improving transparency.

There is a clear risk to public protection where a concern about a doctor's fitness to practise has been raised but cannot be investigated other than by means of an assessment and the doctor refuses to comply with such a reasonable request or having agreed to the request refuses to comply with the reasonable requests of the assessor during the assessment. The

absence of such evidence may interfere with the ability to take forward a case on grounds of impairment.

Where a case is referred to a tribunal to consider a sanction the registrant will have the opportunity to be heard. By these means they will be able to explain if they think that they have complied or if they think there are good reasons as to why they have not done so or why they should not be subject to sanctions. In particular they will be able to raise if they consider that the assessment should not have been directed or that its requirements were unreasonable and the tribunal would need to take such matters into account. It will also be possible by these means for the tribunal to consider matters such as the effect of any health condition that the registrant may be suffering from. The tribunal will be required to have regard to the over-arching objective of public protection and they will need to exercise their discretion consistently with that duty. They will be operating under rules which will be subject to the over-riding objective to secure that cases are dealt with fairly and justly. There will be a right of appeal to the higher courts and any sanction will not take effect while the appeal is pending.

We do not think that interim orders are necessarily sufficient to address the issues raised by non-compliance with these assessments and we think it is better to have the bespoke provisions envisaged by these proposals.

As a result we consider that these proposals are a proportionate mechanism to minimise the potential risks to public protection.

Similar reasons apply in relation to failures to comply with language assessments and our Order will amend the existing provisions enabling sanctions concerning non-compliance with language assessments to ensure consistency and that the GMC can refer cases to the MPTS for it to arrange consideration by a medical practitioners tribunal in the same way.

We propose to proceed with these proposals.

Agree	Disagree	Agree (except in health cases)	No comment
30%	58%	4%	8%
24	47	3	7

Q 17: Do you agree with the proposal to enable medical practitioners tribunals to require review of their directions before expiry?

35% of respondents agreed that it was appropriate to enable medical practitioners tribunals to require a review of their directions before expiry unless the tribunal directed otherwise in the order itself. Some respondents suggested that there should be a systematic review of all orders however the majority of respondents who made comments felt that the permissive approach was sufficiently robust to enable further action to be taken as necessary but would not create unnecessary bureaucracy.

Although 54% of respondents disagreed with this proposal (which included the group of 39 co-ordinated responses), only one of those respondents made any comment as to why. That respondent commented that any directions should be aimed at remedying the problem and

should not require review. We disagree as, for example in performance cases, the GMC will need to be assured that any concern has in fact been remedied before any restrictions are lifted and without the ability for a medical practitioners tribunal to review the order, this would not be possible and would create an unacceptable risk to public protection.

A further 11% of respondents did not comment on this question.

We propose to proceed with this proposal.

Agree	Disagree	No comment
35%	54%	11%
28	44	9

Rationalising the Medical Act 1983 and Fitness to Practise Rules 2004

Q 18: Do you agree that we should confirm expressly on the face of the Medical Act the powers to close cases at the initial consideration stage, the power to review investigation stage decisions and the public interest test which applies where the matters giving rise to the allegation are more than five years old, but that we should remove the 'exceptional circumstances' element from that test?

74% of respondents agreed that we should confirm on the face of the Medical Act the powers to close cases at the initial consideration stage, the power to review investigation stage decisions and the public interest test which applies where the matters giving rise to the allegation are more than five years old, but that we should remove the 'exceptional circumstances' element from that test. A further 11% of respondents agreed with the proposals except removing the 'exceptional circumstances' element of the public interest test which applies where the matters giving rise to the allegation are more than five years old. In this group of respondents, the MDU and others made the point that it would be difficult for doctors to respond to allegations made after such a length of time and that they should only be made to do so in exceptional circumstances.

5% of respondents disagreed with this proposal. Action *against* Medical Accidents (A_{AMA}) opposed the "five year rule" as a unnecessary on the basis that the GMC should be able to reach a view as to whether a case needs further investigation without reference to such a time limit. They also said that the power to classify a complaint as vexatious was unnecessary as the GMC already has sufficient powers to close cases and should not concern themselves with the intentions of the person who raised the concerns. The same respondent also felt that the public interest test which applies where the matters giving rise to the allegation are more than five years old was entirely unnecessary. They said that the time of events leading to an allegation do not necessarily have any bearing on whether action is need to protect patients or uphold standards and the reputation of the profession now.

We consider that confirming the public interest test which applies where the matters giving rise to the allegation are more than five years old expressly on the fact of the Medical Act is the correct approach. Five years is a reasonable time frame for an allegation to be brought to the GMC and there is no advantage to the system of medical regulation by burdening the system with allegations which are difficult to support with evidence because of the amount of time since the matters giving rise to them, especially given that a medical practitioner tribunal will have to consider whether the doctor's fitness to practise is *currently* impaired. We also remain of the view that removing the 'exceptional circumstances' element will ensure that the GMC are able, in cases where it is in the public interest to do so, to pursue investigations where the matters occurred more than five years ago with greater confidence. While it may be the case that it is difficult for doctors to respond to allegations more than five years after the event, we do not believe that, if it is in the public interest to do so, that this is a sufficient reason to prevent the case from being investigated.

As regards the concern as to whether the power to close vexatious allegations is necessary we understand that the GMC do receive a number of repeat allegations in relation to investigations that have already been closed. We consider that it will help their investigators to concentrate on cases that raise fresh public protection issues if the GMC is able to close cases which do not raise new facts or issues and so do not raise new public protection

concerns and so we are of the view that it is appropriate to include this power on the face of the Medical Act.

MDDUS specifically disagreed with the power to review investigation stage decisions saying that it was potentially dangerous to have an undefined review mechanism which may go against providing certainty and speed of resolution of cases that they felt doctors were entitled to. Another respondent also disagreed with having a power to review investigation stage decisions at the behest of the complainant. We consider however that without such a power, where decisions at the investigation stage have been made but new information comes to light which would have affected that decision or it becomes apparent that the decision is materially flawed in some way, there needs to be a power to review that decision and substitute a new decision if necessary. Without such an ability there is a risk that fitness to practise concerns are not fully investigated and suitably considered by a medical practitioners tribunal.

10% of respondents did not comment on this question.

We propose to proceed with these proposals.

Agree	Agree in part	Disagree	No comment
74%	11%	5%	10%
60	9	4	8

Q 19: Do you agree that we should specifically reflect the new arrangements of the GMC referring a case to the MPTS (rather than directly to a medical practitioners tribunal) by making express provision for their powers to continue investigating and the procedure for cancelling a referral?

26% of respondents agreed with the proposal and a further 4% asked for further clarification. 58% of respondents did not agree although only four of these respondents explained why. Three of these expressed the view that the GMC should only refer a case for a public hearing once they were satisfied that an investigation was complete. The fourth commented, that while it did not disagree with the principle, the drafting in the order was unclear as to whether it was the MPTS or the GMC undertaking the further investigation and that greater clarity should be introduced to ensure that the separation of functions between investigation and adjudication is protected.

The PSA considered that the Act should set out the criteria for cancellation of cases and that a panel and not the registrar should be responsible for over-turning the decisions of case examiners and the investigation committee to refer the cases. Two other respondents raised concerns in these respects.

12% of respondents made no comment in relation to this question.

We consider that it is appropriate for the GMC to continue to be able to undertake investigations after referral to a medical practitioner tribunal hearing. Particularly in performance and health cases, a registrant’s practice may remediate/rehabilitate or deteriorate during this time. It is therefore an important public protection consideration that the GMC is able to present a medical practitioners tribunal with up to date evidence which is relevant to the doctor’s fitness to practise at the time of a hearing.

Equally if it becomes apparent following further investigations or otherwise after a referral has been made that a fitness to practise hearing is no longer necessary or justified then it should be possible for that hearing to be cancelled otherwise the time and resources of those concerned will be spent preparing for and attending a hearing only to have the GMC not present a case.

The drafting of the order does not allow the MPTS to ‘investigate’, but in relation to health, performance or language assessments we propose a rule making power to enable a tribunal to direct the GMC to undertake a performance or health assessment to ensure that it has sufficient information to reach a conclusion about the doctor’s current fitness to practise. Panels already have powers to direct investigations prior to reaching a decision in restoration cases and this would also apply to the tribunals. It would also be able to issue directions as to the need for certain evidence in order to resolve the issues in a case. As above, we believe this is necessary in appropriate cases to protect the public.

In light of the PSA’s concerns and others about criteria of cancellations and who should make the decisions. We have reviewed the provisions. In relation to criteria, we have amended the grounds for cancellations to make clear that the discretion involved is the same discretion that led to the referral in the first place i.e. whether the matter should be considered by a tribunal. We have not attempted to be more specific than that as we would not want to inadvertently omit a justifiable ground, but we believe that this revised approach will provide reassurance that the cancellation power will only be used after appropriate consideration of the merits of the case. We have also amended who may make the decision so that will not always be made by the Registrar but instead have allowed the same discretion in the rules as to who may cancel a case as to who may refer one. That way the rules will be able to provide for cancellation by the Investigation Committee or case examiners. However we do not agree that the decision should be made by the Panel as we consider that the decision as to whether to prosecute the matter by way of a fitness to practise hearing should remain a matter for the investigation arm of the GMC, as opposed to the adjudication arm in the form of the MPTS which is to be tasked with reaching a decision where such a prosecution is brought.

We propose to proceed with this proposal, subject to the amendments stated.

Agree	Disagree	Unsure	No comment
26%	58%	4%	12%
21	47	3	10

Q 20: Do you agree that we should clarify that undertakings can be agreed between the doctor and the GMC at any point following a referral for a public hearing until a determination on impairment has been made and subsequently undertakings should only be agreed by the medical practitioner tribunal itself and subject to appeal/referral to the higher courts?

82% of respondents agreed with the proposal to enable the GMC to agree undertakings at any point following a referral for a public hearing until a determination on impairment has been made and subsequently undertakings should only be agreed by the medical practitioners tribunal itself and subject to appeal/referral to the higher courts.

5% cautiously agreed with the proposal although two of these respondents questioned whether it should be subject to the GMC’s new right of appeal or the PSA’s power to refer

cases to the higher courts. One respondent said that it would not be desirable if doctors were being pressured into accepted undertakings.

One further respondent was neutral on the proposal and 8% of respondents made no comment in relation to this question.

Only three respondents disagreed with this proposal. The PSA in particular did not see the value of undertakings once the proceedings have reached the hearing stage because the medical practitioners tribunal is able to impose conditions to the same effect.

The PSA, NMC and MDDUS also raised the question to what utility undertakings would have after the impairment decision given that it would in any event be open to the medical practitioner tribunal to impose conditions.

In light of views received we have reached the view that allowing undertakings after a hearing has started but prior to a finding of impairment would take the question of impairment out of the hands of the tribunal and that at that stage this would not advance the principle of separation, so we have amended the draft Order to not allow undertakings at that stage. However we do think there is a small amount of scope for the use of undertakings after impairment has been found. The utility of undertakings at this stage is in a small number of cases, principally health, where the ability of the registrant to practice may fluctuate. While conditions require a medical practitioners tribunal to be convened before they can be reviewed and amended as necessary, undertakings agreed at this stage could be reviewed and amended by the GMC itself enabling a swifter reaction. We have therefore retained the ability to agree undertakings at that stage but we have amended the provisions so that in that case the tribunal does not itself agree to undertakings which are agreed with the GMC but is able to take them into account. It would still be open to the medical practitioners tribunal to impose an alternative sanction if they did not agree that the undertakings were sufficient, having regard to the over-arching objective of protecting the public. The rule making power will also enable provision so that a breach of such undertakings or where the GMC decide that undertakings are no longer sufficient would lead to a review by the tribunal and potentially greater sanctions.

Doctors will be free to choose whether to enter into undertakings and we would not expect the GMC to exert pressure for this to happen. If a practitioner does not agree to undertakings the GMC will be able to proceed to seek an appropriate sanction from a medical practitioners tribunal.

Two respondents in favour of the proposal said that they did not think that this provision should be subject to the PSA's power of reference to the relevant higher court or the GMC's new right of appeal. Agreeing undertakings requires both the GMC and the doctor to agree and so it is not generally necessary for the GMC (or the doctor) to be able to mount an appeal in these circumstances and so we have not provided for this. In the case of undertakings agreed prior to a hearing, we regard these as investigation stage decisions and so we have also not provided for the PSA to have a power of reference. The PSA would however have a power to refer the decision of medical practitioners tribunal not to impose a greater sanction of their own where undertakings had been agreed at the hearing stage following a finding of impairment, to the relevant higher court. We consider that this is an important safeguard.

We propose to proceed, subject to the amendments stated.

Agree	Cautiously agree	Disagree	Neutral	No comment
82%	5%	4%	1%	8%
67	4	3	1	7

Q 21: Do you agree that we should close the regulatory gap where, in certain circumstances, an order might lapse during an appeal against a subsequent review order?

Of those respondents who answered this question, 36% supported the proposal.

Although 53% of respondents did not agree with this proposal (including the group of 39 co-ordinated responses), only one of these respondents provided any comment on why. This respondent reiterated the point they made in answer to question 17 that any orders imposing restrictions on practise should be aimed at remedying the problem and there should be no need to review such orders. As with our response to question 17, we think that this would create an unacceptable risk to public protection.

A legal firm raised a further issue where, if a doctor appeals a decision at a review hearing to change an order of suspension to an order for conditions, the suspension will remain in force despite the fact that the panel felt that a suspension was not appropriate and said that this was disproportionate. This is already a feature of the existing legislation, although the amendments proposed will also extend its scope to cover the period during which a case is remitted by the higher courts to a tribunal for disposal. We have considered this issue further and do not believe that applying the new conditions which have been appealed (rather than continuing with the suspension) is an acceptable alternative as one of the grounds for appealing such a decision taken by the doctor would be if the doctor considered the conditions imposed are unworkable and if their concerns prove to be valid this would not provide a sufficient solution in the interim. We have not identified a more proportionate, workable solution to suitably ensure public protection during the period in which an appeal outcome against a review decision is pending than the legislation as it would be amended by our proposal.

A further 11% of respondents made no comment in relation to this question.

We propose to proceed with this proposal.

Agree	Disagree	No comment
36%	53%	11%
29	43	9

Q 22: Do you agree that the Registrar should be able to direct the form and content of professional performance assessments and whether it should be carried out by an individual assessor or an assessment team?

19% of respondents agreed with the proposal. A further 8% agreed with the proposal but made further comments. Some felt that a performance assessment should only be carried out by a team to ensure fairness and that there was no bias. Others stressed the need for

such powers to be exercised fairly and one said that the registrar should not be allowed to make a direction without taking advice from a medically qualified person. One respondent argued there should be a right of appeal against the Registrar's decisions.

63% of the respondents disagreed with the proposal. The majority of these respondents (including the group of 39 co-ordinated responses) did not provide any additional comment as to why. Of those that did provide additional comment, some felt that the current system of performance assessment was robust, fair and worked well. Others disagreed with the proposal enabling the registrar to decide on the form and content of a performance assessment which they felt should always involve a medically qualified person.

A further 10% of respondents did not comment in relation to this question.

Although the power would enable the registrar to direct the form and content of a performance assessment, the Registrar would be able to take the advice of a medically qualified person as to what would be appropriate as needed. We do not think it would be proportionate to mandate this in all cases however as the Registrar will also be able to adopt standard approaches for appropriate cases suitably informed by generic advice from a medically qualified person where necessary. We consider that such assessments are part of the GMC's investigation function and that as the officer co-ordinating the exercise of that function it is right that the Registrar is given this role. We consider that enabling more flexibility in the form and content of performance assessments will enable a significantly more proportionate and responsive approach to the circumstances of the individual case. The Registrar's discretion will need to be exercised fairly and if in a particular case a registrant considered that this has not been the case or had other concerns about the process they would be able to raise this as part of their case before the tribunal.

As regards concerns about the proposal to no longer require the use of a team in all cases, while there may be cases where a team will be necessary, in other cases the assessment in question may only require one individual and it would be disproportionate to require a team in those instances. Whether acting alone or part of a team any assessor would need to have the necessary skills to carry out the assessment in question and would be required to undertake a professional assessment fairly and without bias and to recuse themselves from involvement if they felt that in any particular case there may be a risk of this. We do agree that a performance assessment should always include a person who is medically qualified as an assessor and have made additional provision to require this, including provision enabling the appointment to lists of assessors which are to be drawn from for the purposes of each case. Accordingly the Registrar would not personally be carrying out performance assessments of doctors. We have also clarified that the detailed aspects of assessment procedure not provided for in rules may be determined by the assessors.

We propose to proceed with this proposal, subject to the amendments stated.

Agree	Agree in part	Disagree	No comment
19%	8%	63%	10%
15	7	51	8

Q 23: Do you agree that the GMC should have the described power in order to investigate the fitness to practise of a doctor who has been erased from the medical register but subsequently makes an application for restoration?

31% of respondents agreed that the GMC should have the power to require an assessment in order to investigate the fitness to practise of a doctor who has been erased from the medical register but subsequently makes an application for restoration by means of a professional performance, health or language assessment.

57% of respondents disagreed with this proposal (including the group of 39 co-ordinated responses) although only four of these respondents provided comments as to why. Two of these respondents felt that such a system would be disproportionate given that the burden was already on the doctor seeking restoration. One respondent questioned whether the power was necessary and could potentially lead to the GMC inappropriately spending money investigating doctors who not on the register. The final respondent who commented stated that the GMC were failing in their statutory function of undertaking investigation. Broader concerns about the GMC are discussed and addressed in relation to question 24 below.

The MPS noted that this could apply to doctors erased from the medical register for administrative reasons or voluntarily. This is the case as, in certain circumstances; doctors can voluntarily erase themselves from the medical register while a fitness to practise investigation is ongoing. In those circumstances we believe it is essential that the GMC can investigate when a doctor who has been voluntarily erased seeks to restore if there are fitness to practise concerns. However the power is not intended to enable a blanket approach where there are no fitness to practise concerns.

A further 12% of respondents did not comment in relation to this question.

There is already existing provision enabling a fitness to practise panel to require investigations to be carried out prior to making a restoration decision. That principle is underpinned by the need to have clear evidence on fitness to practise to ensure public protection. Expressly confirming that this can include relevant assessments reflects the valuable role that such assessments can play in helping to establish a registrant's fitness to practise. We consider that this power is necessary to ensure that the GMC are able to present evidence at a restoration hearing on the doctor's current fitness to practise rather than relying on historical evidence.

We propose to proceed with this proposal.

Agree	Disagree	No comment
31%	57%	12%
25	46	10

Q 24: Do you have any other comments on the proposals contained in the draft Order?

Many of the responses to this question made further points in relation to the subject matter of other questions and where the issues have been addressed above they have not been repeated.

The Scottish Government Health Departments, while not commenting on the detail of any of the proposals, stated that this package of proposals would create greater inconsistency between the GMC and the other healthcare professional bodies fitness to practise procedures. The Scottish Government Health Departments expressed support for a wider Bill, building on the Law Commissions' review of the regulation of health care professionals, to address the broader issue of consistency. The NMC and another respondent expressed similar views and the GMC made the case that, although welcome, the reforms in this section 60 order were not a substitute for the much more fundamental and wide ranging legislative reforms that they thought were needed to ensure that medical regulation as a whole remains fit for purpose in the future. This was echoed by the PSA who stated that it is important that any changes to the healthcare professional regulatory framework via section 60 orders did not lose the important agenda of consistency championed by the Law Commissions.

Although a Bill has not been included in this session, the Government has committed to legislating on this issue when Parliamentary time allows. We will be publishing our response to the Law Commissions' review in due course. This is a complex area and we need to ensure that any Bill is fully considered and right for patients and professionals.

In the meantime we are taking forward this section 60 order, for the reasons already given the Executive Summary and Background to this consultation report.

A number of respondents stressed the importance of the GMC investigating cases speedily and the MPTS hearing cases expeditiously. We confirm that the proposals are intended to help in this respect.

One respondent stated that there was no need for greater powers to be given to the GMC but rather the emphasis should be on using existing legislation more effectively. We disagree. The changes in order to establish the MPTS's statutory role are significant and alongside those we consider that the right approach has been to also make changes which not only bring in other important reforms but also improve the transparency and clarity of the legislation.

A number of respondents expressed concerns about the consultation process, and questioned the consultation length, target audience and the promotion of the consultation going live. In July 2012 the Government published new Consultation Principles, as part of the Civil Service Reform Plan. This consultation was in keeping with those principles. This eight week consultation received 81 responses, from a wide range of contributors. This included medical professionals, medical defence organisations, legal professionals, patient representation organisations, organisations representing doctors, regulatory bodies, healthcare recruitment, Devolved Administrations and a private consultancy. The GMC had also undertaken a full public consultation on modernising its adjudication processes in 2011 and the government was able to take into account the views arising out of that during its policy development. The Law Commission's consultation and report have also made a valuable contribution. As set out in the Government's Consultation Principles, departments follow a range of timescales rather than defaulting to a 12 week period, particularly, as in this case, where engagement has occurred before. To ensure we received the important views of key stakeholders for the whole of the UK, as part of the consultation launch, 82 stakeholders, covering the groups mentioned above, were identified and proactively notified directly by email, and asked to take part in the consultation. We also worked with the GMC and the PSA to ensure they both promoted the consultation.

One respondent stated that the Department of Health had failed to draw consultees attention to the current standards of proof used in MPTS tribunal hearings. As no change was being made in that respect it was not a direct issue in the consultation but in the response to question 12 we make it clear the civil standard of proof will still apply, as now, to finding of facts stage in a fitness to practise hearing. Further details can be found in the response at question 12 in this document.

One respondent suggested that the GMC's adjudication function should be subsumed into Her Majesty's Courts and Tribunal Service. This was considered as part of the 2010 consultation on the abolition of OHPA it was decided not to proceed with this option owing to practical difficulties, which would still apply. This is also discussed in relation to question 1.

The Royal College of Anaesthetists expressed concern about doctors having been suspended or erased from the medical register in the UK being able to obtain work overseas. Although this is outside the scope of this consultation paper, the GMC do exchange information, via the Decisions Circular as a matter of routine with overseas competent authorities when a decision to restrict a doctor's practice has been made and all decisions are available on the online list of registered medical practitioners. While sanctions on a doctor's registration are only applicable to the UK, overseas healthcare regulators may take this information into consideration as part of their regulatory processes.

A significant number of respondents stated that they felt that only complete separation from GMC by the MPTS would give it any credibility. The department's decision not to proceed with OHPA (which was completely separate from GMC) was taken in 2011. The consultation report in relation to that can be found at [DH Consultation](#) and the approach was endorsed and implemented by Parliament in the Health and Social Care Act 2012. The government considers that that was the right decision and this consultation follows it by raising the question of how to enhance separation and assure the independence of decision making at fitness to practise panel hearings while still retaining the adjudication function within the GMC. We consider that establishing the MPTS as a statutory committee of the GMC is the right means of achieving this. This is addressed in more detail at question 1 of this response document.

The responses from the co-ordinated group of 39 individuals made a number of points which are set out below (although not all views were expressed by all of them) and in each case are followed by the government's view:

1. They consider that a number of the questions in the consultation indicate non-compliance by the GMC's rules and that GMC Professional Conduct Committees, Interim Order Panels, Fitness-to-Practise Panels, OHPA and that the MPTS are closet adjudicators and have proved ineffective and a colossal waste. They do not however specify any particular non-compliance and we have no reason to conclude that there is any non-compliance. The professional conduct committees have been replaced and OHPA has been abolished. None of the bodies referred to operate secretly and the aim of the MPTS and the panels referred to is to ensure effective fitness to practise.
2. They consider that the current fitness to practise rules are incompatible with the Human Rights Act 1998 and the Equality Act, 2010, but they do not specify in what respect they consider this to be the case and the government has no reason to conclude it is the case.

3. They argue that the MPTS is currently operating illegally without any statutory backing and that decisions by 'MPTS-panels' must be declared 'null and void'. However fitness to practise panels and interim orders panels are established by statute and the MPTS is a committee of the GMC established under statutory powers.
4. They argue that the consultation is not sufficient to address the defects and that the GMC and it are not fit for purpose. However for the reasons given in the consultation and this response we do consider that this consultation will bring worthwhile improvements. The GMC is established by Act of Parliament and its functions are conferred by the Act. There is no persuasive evidence that it is not carrying these out. The PSA monitors the GMC's work and has not reached the view that it is unfit to regulate. In their Annual Accounts and Performance Review Report 2013/14, they state; 'In the performance review 2012/13, we found that the GMC met all the Standards of Good Regulation. In 2013/14, we found that the GMC continued to meet all the Standards of Good Regulation'.
5. They argue the GMC is not independent of the government and acts as a licensing department of NHS, which they consider to be a government monopoly. However, the GMC is established by Act of Parliament which establishes its functions and accountability and it is accountable to Parliament and the Privy Council. The NHS is also established by act of Parliament and is not a government monopoly.
6. They argue that the GMC has been publicly found to be 'not fit for its statutory purpose of protecting patients' from bad, dangerous or dishonest doctors, due to a 'culture of mutual self-interest (with culprits)' and that the GMC's bureaucracy has a pro-NHS agenda of protecting dangerous & dishonest doctors employed within the UK NHS, relying on inquiries in relation to Shipman, Neale, Kerr-Haslam, Barton, Chapman, Bradbury, *et al* and '100s of GPs'. They argue the situation has worsened over past decade. However we consider that while improvements to its functions and powers will be made by our proposals, in addition to other improvements that have been made over the past decade, there is no persuasive evidence that it is not currently carrying out its statutory obligations as required.
7. They argue that the GMC is a body totally unsuitable for protecting patients and has already been found to be in breach of its statutory duty of 'protecting patients'. They assert that it is wholly unaccountable to patients, relatives, any UK court, tribunal or the UK Parliament as well as the Charity Commission. However as stated above, while improvements to its powers will be made by our proposals, in addition to other improvements that have been made over the past decade, it is accountable and there is no persuasive evidence that it is not carrying out its statutory obligations as required.
8. They argue the GMC is committing fraud by misrepresenting its status as a charity when all its income is by mandatory levies on doctors so as to avoid paying tax. The Charity Commission considered an application from the General Medical Council for registration as a charity. The Commissioners having considered the case which had been put to them by the GMC involving detailed legal submissions and full supporting evidence concluded, in April 2001, that the GMC is a charity and accordingly is registrable with the Commission pursuant to section 3(2) of the Charities Act 1993. Based on this evidence we do not see any case to suggest that the GMC is acting fraudulently or misrepresenting its status as a confirmed charity.

9. They argue the GMC is committing fraud by misinformation on its website and is falsely exaggerating its statutory powers to regulate medical practice in the UK and is in breach of the Medical Act 1983. The GMC's website is maintained in pursuance of its statutory functions and should be accurate. It is not specified in what respect it is exaggerating these. There is no persuasive evidence to show the information on the GMC website is exaggerating its statutory powers, or that it is in breach of the Medical Act.
10. They argue that the Chair of the GMC, Chief Executive and Council employees routinely commit perjury to mislead UK Parliamentary Health Select Committee, the public, judiciary and the media. In performing their duties, GMC members uphold the principles first identified by the Nolan Committee in its first report on standards in public life in May 1995 (the Nolan principles), and updated by the Committee on Standards in Public Life in its report of January 2013. The GMC adopts and complies with appropriate standards of conduct, all GMC members are required to confirm their commitment to the Members' Code of Conduct. There is no persuasive evidence that the GMC routinely commits perjury or is seeking to mislead the public.
11. They argue that the GMC staff and agents indulge in criminal acts of fraud, forgery, tax-evasion, fabrication and falsification of evidence, perjury, theft, harassment and intimidation. As stated above the GMC uphold the Nolan Principles, and a commitment to the Members' Code of Conduct. The GMC publishes a register of interests, which contains the declared interests on their public facing website. There is no persuasive evidence that GMC and their staff indulge in criminal acts of fraud, forgery, tax-evasion, fabrication and falsification of evidence, perjury, theft, harassment and intimidation.
12. They argue that the GMC is a "tax dodge charity" and a body totally useless for, and already severally in breach of its statutory duty of protecting patients. As already stated its charity status is recognised by the Charity Commission. There is no persuasive evidence in support of the allegations.
13. They argue it would be much safer, efficient and a lot more cost effective: (a) to invite tenders in open market for maintenance of Medical and Specialist Registers, (b) for a separate body other than the GMC to handle complaints against professionals, (c) for professional regulation handled by statutorily independent employment tribunals or county courts, (d) for claims of "professional negligence" to be adjudicated by county courts. The GMC is the body tasked with the maintenance of the registers, and the handling of and adjudication of complaints. There is no persuasive evidence to indicate that it should not continue to be so. Employment tribunals and county courts are not suited to this role. "Professional negligence" is a separate matter from the professional regulation for which the GMC is responsible.
14. They argue that the GMC is a criminal and arrogant mafia totally useless for protecting patients and wholly unaccountable to patients, relatives, any UK court, tribunal or the UK Parliament. The GMC is accountable to Parliament and its decisions are subject to the UK courts. There is no persuasive evidence to support the allegations.
15. They argue that the Order will not rectify the flaws and illegalities in fitness to practise procedures, bar maintaining the existence of the "unfit to regulate" GMC. The alleged flaws and illegalities are not specified and no persuasive evidence is provided in

support. For reasons already given we do not consider there is any persuasive evidence that the GC is not fit to regulate.

16. They refer to a report by Civitas and allege that 75% of suspensions are made without inquiry into the veracity of allegations against doctors from black and ethnic minorities, non-NHS private locums and overseas qualified doctors. They consider the GMC discriminates by fast-tracking complaints from NHS employers and the establishment. They consider that the GMC use unqualified staff to make the regulatory decisions that fall to be made by a panel. They consider that the doctors they refer to are trapped in the GMC's rules with no exit from endless circular procedures with pre-determined outcomes, on which there is no time-limit, reprieve, costs-reimbursement, just remedy or redress. They consider that the GMC's fitness to practice procedure rules are fundamentally flawed and incompatible with the Human Rights Act 1998. These allegations are also raised in relation to question 26 and the government's response is given there.

A further respondent also expressed no confidence in the MPTS stating that they did not feel it was being adequately held to account by Parliament and argued that in a case against a friend, who was removed from the register, that the only reason for doing so must have been racism. The MPTS is presently established as a committee of the GMC under powers held by the GMC in that regard. The GMC is accountable for its actions to Parliament through its annual report and accounts. The new measures proposed will establish the MPTS on a more formal statutory footing, the rules setting out its constitution will be laid before Parliament and subject to the negative resolution procedure and there will be a requirement for a separate annual report in respect of the MPTS's functions to be laid before Parliament. This report will be required to include a report which includes a description of the arrangements that the MPTS have put in place to ensure that they adhere to good practice in relation to equality and diversity. The actions of its staff and tribunals should comply with the Equality Act 2010. If there are concerns about racism in a particular case these should be raised with the GMC. The government is not able to comment on the merits of individual fitness to practise cases but the fact that a panel did not find in an individual's favour does not in itself demonstrate that this must be because of racism.

Another respondent argued that trawling for minor misdemeanours should be prohibited, lack of resources should be a defence and if a defendant is in hospital any hearing should be postponed. These are all issues which taken out of the context of a specific case it is not possible to give a view on. The government is not able to become involved in individual cases.

Q25: Will the proposed changes affect the costs or administrative burden on your organisation or those you represent, by way of:

- **An increase;**
- **A decrease; or**
- **Stay the same**

- **Please explain your answer.**

62% of respondents thought that there would be an increase in costs or administrative burdens. This group included the 39 co-ordinated responses which did not express a view as to what those increase costs would be but rather proposed that the GMC's adjudication function should

be put out to tender and repeated their argument for an independent body. The reasons why we do not propose to do this are discussed in our response to question 1.

Some of these respondents who represent doctors at legal proceedings identified that there is likely to be an increase in costs because of the power for the MPTS to award costs and the potential for satellite litigation. They had similar concerns in relation to other measures designed to ensure compliance with investigations and rules and directions. However, these costs will only arise if there is argued to be a breach of rules or directions or other unreasonable behaviour and in such circumstances we consider any additional costs should be viewed against the benefits to be gained from regulating such behaviour in ensuring effective public protection and as such would be proportionate.

One respondent argued that the objective of maintaining public confidence in the profession would lead to greater litigation in fitness to practise proceedings. In one respect that objective is a codification of an existing objective in the case law and so we would not expect it to lead to a substantial increase but to the extent that it does lead to some increase while its full impact is resolved we would expect this to be transitory and justified and proportionate to the benefit to be gained from expressly including it in the Act so as to ensure its due consideration in all relevant cases.

The PSA also considered there would be an increase in costs associated with the process of determining whether to join a GMC appeal as an interested party and in additional litigation arising from the change in the grounds of reference for the PSA and the new GMC appeal power. Any costs involved in settling the meaning of the changes referred to should be transitory and we do not consider that they would outweigh the benefits of the changes. We also note that there should also be costs savings which can be offset against any increase because the onus will fall on the GMC rather than the PSA to actively pursue those cases which it has appealed, particularly where the PSA does not consider there is a need for it to make representations of its own.

In relation to the administrative burden on the GMC, the GMC support the proposed changes. Some proposals will reduce the administrative burden in the long term and while others may lead to a small increase in the burden, after their impacts have been offset we consider that any effect will be proportionate and acceptable when considering the merits of the proposals.

10% of respondents felt that the costs would likely stay the same, while 1% was unsure. Two further respondents expressed the opinion that the costs were likely to fall on individual doctors going through the fitness to practise process and those supporting them.

25% of respondents did not provide any comment on this question.

The government considers that many of the proposals will increase efficiency and the speed of proceedings and these measures will help to save costs for all parties. Further we consider that there is substantial merit in the proposals and this should be balanced against any costs increase. While respondents have identified certain areas which could lead to an increase in costs, the nature of the changes are such that any such increase should not be too substantial when considered against their merits and the fact that they will also be offset wholly or in part by other cost reductions.

We consider that the proposals will therefore have a proportionate and acceptable outcome in terms of impact on costs and administrative burdens.

Increase	Decrease	Same	Unsure	No comment	Other
62%	0%	10%	1%	25%	2%
50	0	8	1	20	2

Q 26: Do you think that any of the proposals would help achieve any of the following aims:

- **Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010?**
- **Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?**
- **Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?**

If yes, could the proposals be changed so that they are more effective in doing so?

If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?

60% of consultation respondents did not think that the proposals would help achieve the aims set out in the public sector equality duty. The greatest majority of these were from the group of 39 co-ordinated responses. Of the others, in the case of one respondent who gave a view the respondent concerned did not consider that the proposals will have an effect one way or the other, and this may also be the case for some of those who did not give views.

The co-ordinated group of 39 respondents allege that the GMC is unfit to regulate and that a large proportion of sanctions are made without any inquiry into the veracity of allegations against doctors who are over-seas qualified or are black or from ethnic minorities and non-NHS private locums. They refer to a report by Civitas. They consider the GMC discriminates by fast-tracking complaints from NHS employers and the establishment. They consider that the GMC use unqualified staff to make the regulatory decisions that fall to be made by a panel. They consider that the doctors they refer to are trapped in the GMC's rules with no exit from endless circular procedures with pre-determined outcomes, on which there is no time-limit, reprieve, costs-reimbursement, just remedy or redress. They consider that the GMC's fitness to practice procedure rules are fundamentally flawed and incompatible with the Human Rights Act 1998 and the Equality Act, 2010.

The co-ordinated group of 39 respondents reference the Civitas paper, *The General Medical Council: Fit to Practise?*² which raised concerns about the GMC's ability to regulate, and recommended the re-appraisal of the purpose and scope of the GMC. We do not agree with this paper or its conclusions, as it presents no strong evidence to support these concerns. The PSA monitors the GMC's work and has not reached the view that it is unfit to regulate. In their Annual Accounts and Performance Review Report 2013/14, they state; 'In the performance review

² Williams, H *et al*, 2014, *The General Medical Council: Fit to Practise?*

2012/13, we found that the GMC met all the Standards of Good Regulation. In 2013/14, we found that the GMC continued to meet all the Standards of Good Regulation'. While allegations relating to certain matters, such as those relating to criminal convictions, are referred directly to a panel, other allegations are subject to investigations before being referred or a decision to not take it forward is made or a warning is issued. A warning will be issued by an Investigation Committee or case examiners to whom that function has been delegated in accordance with the Medical Act 1983. The MPTS should ensure that its panels, committees and case examiners have the necessary skills to carry out these tasks and exercise them without pre-determination and in accordance with the requirements of the Equality Act 2010 and the Human Rights Act 2008. The proposals will make the MPTS's responsibilities in this regard more transparent and have a positive effect in this respect. The GMC deal with a large number of serious concerns from NHS employers and public bodies and will need to address these with regard to the seriousness of the allegations. Where necessary they are able to seek interim orders to protect the public or where it is otherwise in the public interest while they undertake their investigations.

The proceedings will lead to a hearing and a final outcome and if a direction is issued this may be subject to review or a number of reviews, and possible extension to ensure public protection, before it ends. Erasure from the register will be permanent unless a subsequent successful application for restoration is made. The practitioner has a right of appeal against directions to the higher courts. It is not an endless process in itself nor without the opportunity for the practitioner to seek their preferred result through a fair hearing. The existing process is intended to be fair and just but the proposals will underline this by means of an over-riding objective for relevant rules made by the GMC to secure that cases are dealt with fairly and justly. The provisions will also enhance pre-hearing case management and the ability of parties to seek costs if the other party behaves unreasonably. The government does not consider that the assertions of this group of 39 co-ordinated responses demonstrate that GMC's fitness to practise rules are fundamentally flawed or incompatible with the Human Rights Act 2008 or the Equality Act 2010.

As respects the specific concerns of the group of 39 co-ordinated respondents about doctors who are from black or from ethnic minorities, overseas or non-NHS private locums, evidence indicates that there are a range of factors that increase the risk of referral to and progress through fitness to practice proceedings. There is some evidence that doctors from black and ethnic minorities are more likely to be complained about, and therefore to become subject to fitness to practise proceedings, than white doctors. There is further evidence that suggests that this is related to the place of qualification rather than race, but nevertheless we have considered our proposals in light of the possibility that there may be relatively more doctors from black and ethnic minorities affected by them by virtue of a greater proportion being subject to complaints and fitness to practise proceedings. We have similarly looked at the proposals in respect of overseas trained doctors and in respect of locums from outside the NHS as these also fell within the concerns of the co-ordinated group of responses and may also contain a greater proportion of persons with a protected characteristic related to race.

A number of the proposals will have positive equality impacts which will help to advance one or more of the three aims referred to in the public sector equality duty (as identified in the question), including the following:

1. The Order establishes the MPTS as a more separate quasi-judicial arm of the GMC to deal with fitness to practise adjudication distinct from its investigation functions and other functions. This will help to emphasise the importance to all involved of fair and robust decision making.

2. Fair and just proceedings will be supported by the introduction by the Order of an overriding objective of the GMC when making rules to secure its fitness to practise committees and tribunals deal with cases fairly and justly.
3. The Order establishes a mechanism for the appointment of the MPTS and its staff and panellists through which it will be possible to reflect best practise in terms of equality and diversity. This will benefit those appointed and those who are involved in proceedings conducted by the MPTS's tribunals.
4. The GMC will be subject to a new duty to specifically report on the exercise of the MPTS functions which is to include a description of the arrangements that the MPTS have put in place to ensure that they adhere to good practice in relation to equality and diversity. This report must be laid before Parliament by the Privy Council. Until now the GMC's annual reports were not subject to a specific separate requirement in relation to their fitness to practise adjudication functions.
5. The MPTS will be required to keep a register of its members' interests which will help to avoid bias.
6. Enhanced case management will help to ensure that the proceedings are conducted fairly and justly, and will enable consideration of the needs of those with protected characteristics.
7. Enabling reviews of directions without requiring hearings, the cancellation of unnecessary hearings and the agreement of undertakings, subject to safeguards, will avoid the need for attendance of practitioners and witnesses with protected characteristics which may make attendance at such hearings difficult.
8. Enabling documents to be served on doctors by electronic means where the doctor has agreed will be helpful for those who by virtue of protected characteristics find electronic communication more accessible.

Many of these will benefit doctors from black and ethnic minorities, overseas trained doctors and locums from outside the NHS. To the extent that they are subject to a greater proportion of fitness to practise proceedings than others, this will be to a greater extent than for protected groups who are not subject to greater numbers of fitness to practise proceedings. To the extent that this will therefore have a greater beneficial impact for these groups this is justified as a proportionate means of achieving a legitimate aim.

The remaining proposals will generally improve the effectiveness of regulation, with, in some cases, further positive equality impacts including helping to ensure that doctors who are not observing acceptable standards in relation to equality and diversity can be subject to effective regulatory action. In particular the new over-arching objective and the duty to have regard to it, when determining fitness to practise and issuing sanctions, and the revised grounds for referrals by the PSA and the GMC's right of appeal to the higher courts, will help to reinforce this because it emphasises that the over-arching objective of public protection involves promoting and maintaining confidence in the profession and proper professional standards and conduct, which may include matters of equality and diversity.

Depending on the circumstances of a doctor who is subject to fitness to practise proceedings, some of the proposed measures may also impose burdens in order to ensure effective public protection where there is no immediate benefit to equality. These measures will be required to

be applied in accordance with the Equality Act 2010 and many of them will be subject to the over-riding objective of rules to secure that cases are dealt with fairly and justly. We do not consider that there should be any differential impact or less favourable treatment for individuals from these groups on account of their race and we consider that any impact is justified on the basis that the measures are intended to be a proportionate means of achieving a legitimate public protection aim. And we consider that any increased impact on those from black and ethnic minorities or those trained overseas or on locums from outside the NHS by virtue of their potential higher numbers involved in fitness to practise processes relative to the rest of the medical population is justified on the basis that the measures are intended to be a proportionate means of achieving a legitimate public protection aim.

Other views expressed by those who responded in the negative were:

1. One respondent considered the proposals discussed at questions 9, 16 and 23 will be less fair than existing arrangements.

As respects question 9, matters of professional registration are serious and we consider that most registrants, including those with a protected characteristic, would not compromise their position in order to avoid a hearing. Certainly we would not expect the GMC to exert pressure for that to happen. The GMC have committed to ensuring that information will be delivered in accessible formats and that there is sufficient time within the process to enable a doctor to discuss it with an adviser. There will be additional safeguards that if the chair or tribunal considering the agreed outcome believe it is potentially too severe or otherwise wrong they would be able to convene a hearing to consider the matter further. Accordingly we believe that any potential disadvantages can be avoided.

Further this policy will have a positive impact on doctors with health conditions on account of disability who are subject to the fitness to practise procedures as well as persons with a disability who may be providing evidence to be considered by a medical practitioners tribunal during their deliberations. Brooks *et al*³ report that the nature of GMC hearings, being like a court room, are anxiety provoking so enabling review hearings by consent should reduce the stress for doctors and witnesses with disability by enabling orders to be reviewed without a hearing.

Accordingly, we consider that this proposal will enable a more proportionate means of pursuing a legitimate public protection aim.

As respects question 16, as stated in response to that question there is a clear risk to public protection where a concern about a doctor's fitness to practise has been raised but cannot be investigated other than by means of an assessment and the doctor refuses to comply with such a request or having agreed to the request refuses to comply with the reasonable requests of the assessor during the assessment.

Where a case is referred to a tribunal to consider a sanction the registrant will have the opportunity to be heard. By these means they will be able to explain if they think that they have complied or if they think there are good reasons as to why they have not done so or why they should not be subject to sanctions. It will be possible by these means for the tribunal to consider

³ Brooks, S.K., *et al*, 2014, Sick doctors' experiences of interactions with the General Medical Council, *BMJ Open* 2014;4:e005537. doi:10.1136/bmjopen-2014-005537

matters such as the effect of any protected characteristics. The tribunal will be required to have regard to the over-arching objective of public protection and they will need to exercise their discretion consistently with that duty. They will be operating under rules which will be subject to the over-riding objective to secure that cases are dealt with fairly and justly. There will be a right of appeal to the higher courts and any sanction will not take effect while the appeal is pending. Accordingly the circumstances should ensure that it is only applied fairly and in accordance with the Equality Act 2010.

To the extent that this will proposal will affect greater numbers of groups of doctors with particular protected characteristics, such as those with health conditions on account of disability who may be subject to health assessments, we consider it to be justified as a proportionate means of pursuing a legitimate aim by minimising the potential risks to public protection.

As respects question 23, there is already existing provision enabling a fitness to practise panel to require investigations to be carried out prior to making a restoration decision. That principle is underpinned by the need to have clear evidence on fitness to practise to ensure public protection. Expressly confirming that this can include relevant assessments reflects the valuable role that such assessments can play in helping to establish a registrant's fitness to practise. We consider that this power is necessary to ensure that, where needed, the GMC are able to present evidence at a restoration hearing on the doctor's current fitness to practise rather than relying on historical evidence. It should only be applied where needed and in accordance with the Equality Act 2010. Further, we consider that this proposal will enable a more proportionate means of pursuing a legitimate public protection aim.

2. A lack of confidence in the MPTS was expressed.

For similar reasons to those given in relation to the co-ordinated group of 39 responses above, we are not persuaded that this is the case.

3. One respondent considered that the fact that the MPTS is a branch of the GMC is unfair and only complete separation would give it credibility.

The argument that the adjudication function should be entirely separate was addressed above in relation to consultation question 1. For the reasons given immediately above in relation to the group of 39 co-ordinated responses, we consider that the proposed arrangements for the MPTS will bring an improvement in terms of equality.

4. One respondent considered that some proposals will distort equality of opportunity and risk fostering poor relations and the proposals will not play any role in eliminating acts contravening the Equality Act 2010.

The respondent did not specify in what respect. However, we have considered the proposals in relation to all protected characteristics in order to consider their impact in accordance with the public sector equality duty. We consider that each proposal will have either positive or neutral impacts on the three aims referred to in the public sector equality duty. For instance, the response to the concerns of the group of 39 co-ordinated respondents above lists 8 policies which will each have a positive impact on one or more of the aims, and in particular we consider that establishing the MPTS as a statutory committee, required to report on equality and diversity in its annual report to Parliament, and introducing the over-riding objective in respect of its rules will help to promote fairness and equality and, in doing so, advance all three aims.

Depending on the circumstances, some of the measures may impose burdens in order to ensure effective public protection where there is no immediate benefit to equality. But we have taken into account the needs of those with protected characteristics and less favourable treatment on account of a protected characteristic will be avoided. The measures will be applied in accordance with the Equality Act 2010. Any increased impacts for particular protected characteristics by virtue of greater proportions being subject to fitness to practise proceedings or particular policies relative to others are justified on the basis that the measures are a proportionate means of achieving a legitimate public protection aim.

5. One respondent considered that the proposals include provisions for subjective judgments about “public confidence” which affords scope for perpetuating prejudices and discrimination.

As explained in relation to consultation question 11, those tasked with considering whether public confidence in the profession will be affected are being asked to make an objective judgement of their own as to whether particular acts or omissions would affect public confidence if no action were taken rather than to seek out the views of the public or the media as to what they think should be done. Any such view would need to be in accordance with the Equality Act 2010 itself and as such it should not perpetuate prejudice or discrimination. The relevance of public confidence in the profession or the reputation in the profession as a basis for fitness to practise action and to help ensure public protection is established in case law and its express inclusion in the over-arching objective will help to ensure it is given due weight in all cases. It is also considered that it is a proportionate means of achieving the legitimate public protection aim.

As also stated above in relation to the co-ordinated group of 39 responses, the new objective and the duty to have regard to it, by emphasising that the over-arching objective of public protection involves promoting and maintaining confidence in the profession and proper professional standards and conduct, will mean that cases where a doctor has not acted in accordance with appropriate standards of equality and diversity will be more obviously within the scope fitness to practise proceedings and this will help to advance the three of the aims referred to in the public sector equality duty.

6. Costs sanctions are likely to have a disproportionate effect on doctors who are not members of a medical defence union or are undefended. There are a large number of doctors who qualified outside the UK who fall into this category and costs sanctions, and some other proposals, will fall disproportionately on this group of doctors.

The use of case managers prior to hearings and legal assessors or legally qualified chairs during hearings will help ensure that a doctor who otherwise lacks access to legal advice understand their responsibilities and avoids what would constitute unreasonable behaviour. The power to make rules for the award of costs will be subject to a power to take into account the ability of the party to pay and this will enable the tribunal to take into account where a party has limited resources on account of a protected characteristic. The rules will be subject to the over-riding objective, public consultation and Parliamentary process and this should also ensure that they are fair. The provisions will ensure that costs sanctions can only be applied where a party acts unreasonably in proceedings. Unreasonable conduct in this way can impede the public protection objective. The use of costs to control this will be applied in accordance with the Equality Act 2010 and the over-riding objective and will be a proportionate means of achieving the legitimate aims of public protection and fairness. In addition effective case management will have positive equality impacts by ensuring fairness and that the needs of those with protected characteristics can be taken into account and the use of costs will help to support this and

ensure proceedings are effective and that all parties understand requirements and what behaviour is expected to enable the hearing to run smoothly. We believe that this is a proportionate means of achieving the legitimate aim of fairness and public protection for the same reasons as discussed above.

7. One respondent considered that the proposals will not foster good relationships between people.

We do not agree for the reasons given above in relation to point 4.

8. One respondent argued that a legal assessor helps witnesses and unrepresented doctors (the majority of whom they considered may have a protected characteristic) and all parties are informed of their advice, and expressed concern that legally qualified chairs would not be able to deliver the same advice. They argued that the criteria for choosing whether to have a legal assessor should avoid disadvantaging the doctor and be transparent.

However the Order will provide that if there is not a legally qualified chair there must always be a legal assessor. Where there is a legally qualified chair they will be able to advise on exactly the same matters and will be required to inform the parties of that advice. The GMC will also be able to appoint a legal assessor as well where it considers this would be of assistance in a particular case. By these means we consider that witnesses or unrepresented doctors will continue to be provided with relevant advice and support, including those sharing a protected characteristic, and the transparency of the advice given will continue to be ensured. The policy will be applied in accordance with the Equality Act 2010 and we consider that this will be a proportionate means of achieving a fair hearing and public protection.

20% of respondents did not make a comment in relation to this question.

Yes	No	Same	No comment
4%	60%	15%	20%
3	49	13	16