1. Proposed change: where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor?

Do you agree with this proposal?
YES but …
COMMENTS
Concern that in time period where doctor might be proved innocent
That he/she can be put under financial and mental stress and this will have an adverse outcome on the patients he serves as well as his family and himself.
Whre is the safety net for the carers.

2. Proposed changes:
to guide panels to consider taking action where a doctor's fitness to practise medicine is found to be impaired unless there are exceptional circumstances. To define exceptional circumstances as those that are unusual, special or uncommon. For example, it is not unusual for doctors to express regret for their actions, so this is not an exceptional circumstance.

Do you agree with this proposal?
Yes

3. **Proposed change:** to guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence
in doctors.

Yes

4. **Proposed change:** to guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence

Yes
At what level must the doctor raise concerns; is it to his line ,manager or if he finds nobody listening should he go to the newspaper etc

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

Yes

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

Yes
How do we assess evidence where it is patient's word against the doctor's word
And there is no other evidence or clues available.

7. **Proposed change:** to guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics* in any circumstance, either within or outside their
professional life.

Yes agree but there can bean area where evidence is not clear. 1st recommendation should first be that all doctors are up-to-date on equality and diversity training depending on the severity of the remarks and again what is the evidence? Is it simply doctor's word against the patient(s).

8. **Proposed change:** to guide panels to consider the factors which may lead to more serious action where the following issues arise in a doctor's personal life:

- misconduct involving violence or offences of a sexual nature
- concerns about their behaviour towards children or vulnerable adults
- concerns about probity (being honest and trustworthy and acting with integrity)
- misuse of alcohol or drugs leading to a criminal conviction or caution
- unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation
- any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings

YES
no comments but this would be a criminal case that has to be proven rather than rumour??

9. **Proposed change:** to guide panels that they may consider specific factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. We take all issues relating to drug or alcohol misuse seriously. Some are more serious and have aggravating features and

therefore would attract more serious outcomes. We believe panels should consider more serious action in cases involving the following factors:

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

This approach is consistent with our guidance on assessing the risk posed by doctors with health issues.

YES no comments

10. Do you think panels should require a doctor to apologise where patients have been harmed?

YES but is this as an individual or on behalf of the trust.
Is the mistake purely the consultant/doctor in question??

11. **Proposed change:** to introduce more detailed guidance on the factors that indicate a doctor has or lacks insight.

- A doctor is likely to have genuine insight if they: accept they should have behaved differently, consistently express insight,＊take steps to remediate and apologise at an early stage before the hearing.
- A doctor is likely to lack insight if they: refuse to apologise or accept their mistakes, do not consistently express insight, or fail to tell the truth during the hearing.
- A doctor may also lack insight if they promise to remediate, but fail to take appropriate steps or only do so when prompted or immediately before or during the hearing.

YES

12. **Proposed change:** to guide panels they may consider the stage of a doctor's UK medical career as a mitigating factor, and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. However, in cases involving serious concerns about a doctor's performance or conduct (eg predatory behaviour to establish a relationship with a patient, or serious dishonesty), the stage of a doctor's medical career should not influence a panel's decision on what action to take.

YES

13 and 14. **Proposed change:** to introduce a robust verification process to check the authenticity of testimonials before they are accepted as evidence in a hearing. This would involve checking the identity of anyone who has a written a testimonial to eliminate the possibility of fraud or misrepresentation. We also propose to check that those who write testimonials are aware of the concerns about the doctor, what their testimonials will be used for, and that they are willing to come to the hearing to answer any questions if a panel asks them to do so. To allow sufficient time for checks to take place, doctors will have to submit their testimonials before the hearing starts.

Deciding whether testimonials are relevant

Proposed change: to introduce guidance for panels on the factors they may consider when deciding whether testimonials are relevant to their decision:

- whether the testimonial is relevant to the specific concerns about the doctor
- the extent to which the views expressed in the testimonial are supported by other
- available evidence
- how long the author has known the doctor
- how recently the author has had experience of the doctor's behaviour or work
- the relationship between the author and the doctor (eg a senior colleague)
- whether there is any evidence that the author has a conflict of interest in providing the testimonial (eg personal friendship

YES

15. **Proposed change:** to make sure we routinely request a statement from a doctor's responsible officer* during our investigation for the panel to consider at a hearing. The statement should set out the extent to which the doctor has reflected on the matter before the panel, the extent to which they have shown insight and how far any issues about their performance or behaviour have been addressed. The panel may wish to consider the extent to which any evidence of insight in testimonials provided on the doctor's behalf is supported by other available evidence, including the responsible officer's statement. We would also introduce guidance for panels to make sure doctors who do not have a responsible officer because they have given up their licence, or who are using alternative routes for revalidation, are not treated unfavourably.

YES

16. **Proposed change:** to guide panels they may consider five key factors when deciding the length of suspension:

- the risk to patient safety
- the impact on public confidence in doctors
- the seriousness of the concerns, and any mitigating or aggravating factors (as set out on the opposite page)
- sending a message to the medical profession that standards must be upheld
- ensuring the doctor has adequate time to remediate.

Panels may also wish to consider the time all parties may need to prepare for a review hearing if one is needed.

YES

17. **Proposed change:** where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration.

YES but more detail and clarification needed.

18. **Proposed change:** to provide guidance that suspended doctors should keep their clinical skills up to date by working in ways that do not allow them to be able to play any part in interactions with patients. This would still enable them to observe and
later reflect on clinical care such as observing clinics related to their area of practice and of course by engaging in continuing professional development

YES

19. Where a panel suspends a doctor solely to uphold public confidence in doctors, should any previous interim order influence the panel's decision?

YES but need to know whether it was a related incident and how long ago

20. Do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed?

YES

21. **Issue to consider:** how effective and proportionate is our current warnings system, when should we be able to issue warnings, and should more serious
action be taken where there are repeat low level concerns that involve a serious departure from *Good medical practice*?

This is confusing, the example given is about a road accident unrelated to work.
Also what is low level concern and what is serious departure from good practice in each speciality?

22 When do you think we should be able to give warnings?
a Not in any circumstances.
b Only to deal with low level concerns that involve a significant departure from *Good medical practice* where a doctor's fitness to practise is not impaired.
c Only to deal with misconduct where a doctor's fitness to practise has been found impaired.
d To deal with low level concerns

23 If we continue to give warnings, do you agree that more serious action should be taken where there are repeat low level concerns that involve a significant departure from *Good medical practice*?

YES

24 How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired?
a Publish warnings for five years and disclose to employers and responsible officers indefinitely.
b Publish warnings for one year and disclose to employers and responsible officers for five years.
c Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years. Indefinite disclosure to employers and responsible officers.

'c'