# The GMC's handling of the case of Dr Manjula Arora

## An independent learning review

**Professor Iqbal Singh CBE** and
**Martin Forde KC**

# The GMC's handling of the case of Dr Manjula Arora

## An independent learning review: Professor Iqbal Singh CBE and Martin Forde KC

### Contents

# Foreword

## Compassionate, supportive and fair regulation

The investigation and tribunal hearing of Dr Manjula Arora generated significant anger and anxiety among the medical profession. The case raised once again the perception of a regulatory process lacking in fairness; of a system in which the stakes seem much higher if you are a black and minority ethnic doctor.

The General Medical Council (GMC) acknowledged that strength of feeling, making clear it would not oppose Dr Arora's appeal against the sanction and commissioning a review of the case to understand lessons to be learned for future cases. We were pleased to accept the GMC's request that we co-chair that review and present our findings and recommendations in this report.

We have had conversations with many health, medical, policy and equality leaders and the universal message has been one of hope and expectation that our recommendations will lead to a 21st-century regulation that is compassionate, supportive, fair and caring and that cases similar to Dr Arora's will become 'never events'.

We have been very aware of concerns about this case regarding the need for local resolution and promoting a culture which encourages local resolution, the need for sanctions to be proportionate, and for every step in the decision making process to be free of racial bias, be it actual or perceived. Throughout our review we have also focused on the need to embed compassion and support in the fitness to practise processes and beyond.

Our report and recommendations cover these, and a range of issues for the GMC, from greater consistency in managing concerns so that 'local first' becomes the default; to more rigorous investigation plans and assurance throughout cases to ensure concerns remain issues to be pursued; and crucially to greater levels of cultural competency to better understand the professionals which the GMC regulates.

The diversity of the medical profession has never been greater – 42 per cent of doctors are of black and minority ethnic origin in a workforce heavily reliant on international medical graduates (IMGs). The GMC must continue apace with its offer to aid the induction of IMGs with its *Welcome to UK practice* sessions, but it must also develop greater insight into the cultural norms and experiences of those doctors so that misunderstandings are not compounded by mistakes. We welcome the targets set by the GMC in relation to eliminating disproportionate referrals and differential attainment and appreciate the leadership shown by the GMC's Chair and Chief Executive. We strongly hope that this episode will not delay the GMC in this work.

It must look within itself too. We found investigation processes which were also subject to human variance. At the heart of this case was a misplaced legal test around dishonesty but there was more besides which could have prevented this allegation from progressing and giving rise to the concern felt by doctors. Our review heard from GMC staff concerned at how this case was progressing, but who felt that the investigation process was too big a tanker to turn around. The GMC must engender a culture of curiosity in how it fulfils its statutory duties.

Above all, there must be compassion shown by the GMC in their interactions with doctors, patients and referrers. We know that investigations are hugely stressful for doctors, and an allegation of dishonesty is among the most serious. The evidence for such allegations must be credible and without nuance, and cases approached with an open mind. Where there is doubt, inconsistency or the possibility of nuanced interpretation, dishonesty should not be charged. There must not be a culture of attempting to formulate the most severe charges to enhance likely sanction. And we believe there is a need for the GMC to reconsider what constitutes 'low-level dishonesty', including whether tribunals should be able to find that something was misleading but not done with a dishonest mind.

Regulators should judge their success not by how many fitness to practise referrals they handle but in how they support local systems towards local resolution and remediation when needed. We strongly believe that the GMC's Outreach team has a pivotal role in helping to strengthen this culture. There has been a long wait for the UK Government to undertake legislative reform of professional regulation; such reform will provide the GMC with greater scope to dispose with fitness to practise cases consensually.

Referral to the GMC is hugely stressful and traumatic for any doctors irrespective of the outcome. They often feel trapped, humiliated and ill-treated. Going through such an experience affects not only their physical and mental wellbeing but also their wider families'. It is therefore important that all organisations are able to provide support throughout the whole fitness to practise process and beyond. The need for mentoring, support, remediation and guidance may sometimes be even more important at the end of tribunal hearings and sanctions than during the process itself.

There are many things which the GMC can do to improve matters for those doctors subject to concerns. There is more too which it cannot achieve in isolation, and which will need the combined efforts of others. With that wider support and goodwill, the work currently being undertaken by the GMC on regulatory fairness, and its targets to eradicate disproportionate referrals and differential attainment, can contribute to 21st century regulation, which is truly compassionate, supportive and fair. We ask the GMC to use their influence widely and monitor, evaluate and report progress on these recommendations.

We again express our gratitude and thank the many that have kindly given us their time and helped with this review.

Professor Iqbal Singh CBE

Martin Forde KC

# Executive summary

## About this review and our report

This learning review was commissioned by Charlie Massey, Chief Executive and Registrar of the General Medical Council (GMC), in May 2022.

In doing so, the GMC wanted to understand whether there were lessons to learn from this case that could be applied to future cases. Charlie Massey said:

> *"It is absolutely right that the GMC's decisions about a doctor's ability to practise in the UK are open to scrutiny. I believe that the GMC can be a positive force for improvement, and we will only be able to fulfil that role if we are open to learning from every case that we investigate."*

In June 2022, the GMC appointed us to co-chair and provide external oversight of the review, carried out by Elizabeth Jenkins, Assistant Director for the GMC's legal team. Our terms of reference can be found at Annex A.

We have been provided with access to all the key documentation relating to this case; and a number of people involved in the GMC's handling of it have been interviewed. The GMC has provided us with full support throughout this process on the understanding of our independence. And we have ensured this independence in our findings and recommendations.

Our terms of reference don't include 'putting right' any omissions from the original investigation or decision-making process by requesting further evidence or material. We explored the interactions between the referrer in this case, the GMC fitness to practise teams, and Dr Arora herself, on the basis of information that the GMC had within their possession at the relevant time.

This report does not provide a narrative of what happened through the life of this case. We provide a contextual description for our recommendations at each stage of the fitness to practise process set out in our terms of reference. We have done this to ensure transparency in our findings, while taking care to maintain the confidentiality of Dr Arora, and others involved.

## About the case

In February 2020, Dr Arora's employing organisation (the referrer) raised concerns to the GMC. Following an investigation, the GMC referred two matters to a medical practitioners tribunal. On 12 May 2022 the tribunal published their determination in the case. They found one matter, relating to dishonesty was proved, that Dr Arora's fitness to practise was impaired, and that her licence to practise should be suspended for one month.

On 26 May 2022 the GMC's Chief Executive and Registrar announced a review of this case; and on 22 June 2022 we were appointed as co-chairs.

On 7 June 2022 those representing Dr Arora lodged an appeal against the tribunal's decision, which the GMC swiftly and publicly stated that they would not contest.

On 17 August 2022 the High Court quashed the tribunal's facts determination and consequently their determinations on impairment and sanction. This means that Dr Arora has no findings on her registration.

The GMC has been strongly criticised for their handling of this case by members of the profession and stakeholders, commentators on social media channels, and in trade and national news publications. Some found it difficult to comprehend how the allegations against Dr Arora were not resolved locally and progressed as far as they did. A range of questions were raised about fairness, and there was a clear perception that Dr Arora's experience was representative of how black and minority ethnic doctors are routinely treated within regulatory processes. Others highlighted concerns around cultural awareness within the GMC and queried the apparent lack of compassion in Dr Arora's treatment at the medical practitioners tribunal hearing.

## A summary of our findings

Following our review of Dr Arora's case, we have made 13 recommendations for the GMC, and 5 recommendations for others. Below we provide a thematic summary of our overall findings, addressing three main areas of concern that were raised with the GMC:

1. *A belief that allegations against Dr Arora should have been resolved locally, without reaching the GMC. And that once the matter reached the GMC, that it should not have been referred to the tribunal.*

Our review and terms of reference are structured around what are sometimes referred to as 'high stakes decision points'. This is because such events are key moments in the progression of a case, from receipt of a complaint to its conclusion; and because if the GMC get it wrong at any of these stages it is likely to lead to an adverse impact, whether that be to the doctor, their patients, or to public confidence in the GMC.

At each of these points we considered not just whether the right conclusion was reached, but whether the basis for it took account of the correct information. We also considered whether the GMC set out its thinking appropriately, and in accordance with its existing guidance, policies and processes.

As well as examining how the GMC dealt with this referral, we looked at how the allegations were handled before they reached the regulator. We believe the GMC should have encouraged the referrer to raise concerns with Dr Arora's responsible officer (RO) in the first instance. We recommend that the GMC embeds a culture where referrers are encouraged to seek and feel

responsible for a local first solution, where appropriate and where patient safety is not at risk. However, this should not be seen as a criticism of the referrer's actions in this specific case.

As we followed the progression of this case, we specifically examined how the GMC applied the objective legal test for dishonesty, as laid down in Ivey v Genting Casinos Ltd t/a Crockfords, when they considered the allegation that Dr Arora had lied to obtain a laptop from her employer. This required the GMC to be satisfied that 'ordinary decent people' would describe this allegation as dishonest. And that embellishment or exaggeration in of itself does not necessarily equate to dishonesty.

We find that the GMC incorrectly applied the legal test when considering this particular allegation. They were therefore wrong to conclude that Dr Arora's actions could be said to be objectively dishonest, taking account of the whole of the circumstances. As such, it should not have been taken forward.

We conclude that there were multiple missed opportunities for the GMC to stand back and look at this case again. There were moments where people expressed misgivings about the strength of the evidence, and whether the allegations were sufficiently serious for the GMC to become involved. Those opportunities were not pursued because it was felt unlikely to make a difference. We fundamentally believe that it is important for every individual to add value to the process at each stage.

Our recommendations directly address these findings. They include that the GMC should do more to embed a culture of professional curiosity, including cultural curiosity and speaking up, across all relevant teams. We have also recommended specific process and guidance changes which we believe the GMC can readily implement to make immediate improvements.

2. *The perception that the GMC's decision making in Dr Arora's case was an example of bias, and directly affected by her ethnicity, and that a white doctor would not have had the same experience.*

We understand this perception, and the keen sense of frustration that's been expressed by many following Dr Arora's suspension. It's been at the forefront of our minds throughout our review. We made it a key focus at each stage of our deliberations; and we looked very carefully for evidence of bias in the GMC's decision making.

We make no judgement in relation to bias in this case. We found no clear or conclusive evidence or data to suggest that biased thinking affected this case. However, we also found no evidence or data that would definitively dispel the perception that it was affected by bias. We wish to make it very clear that our comments in no way reflect on any individual decision makers.

We appreciate that in the context of a single case this finding won't answer the concerns of those who believe that black and minority ethnic doctors are routinely discriminated against by GMC processes.

We recognise that no organisation can be genuinely free from bias. They are comprised of individuals with their own values and beliefs, and reflective of society as whole. It's therefore vital that bias is proactively sought out, rather than simply looking for reassurance that it does not exist. This is particularly important for organisations, like the GMC, who work with or serve diverse populations.

We conclude that the GMC should continue to acknowledge and champion their duty and responsibility to embed equality, diversity and inclusion across everything they do. And that they should also accelerate the action they are already taking to ensure their decision-making processes are fair, consistent and free from bias.

Our recommendations directly address these findings. We hope they will help build confidence in the GMC's decision making over time by emphasising the importance of local resolution; enhancing their approach to data collection and monitoring; and embedding cultural competence, diversity intelligence and compassion across the fitness to practise process.

### The GMC's ongoing work in this area

Dr Arora's case was first referred to the GMC in early 2020. In considering the perception that the GMC's decision making in this case was an example of bias, we took the opportunity to look at work already underway across the GMC to promote fairness in their own processes and in the wider healthcare system. This encompasses the action they're taking to implement recommendations from Dr Doyin Atewologun and Roger Kline's Fair to Refer? research[1]. It also includes their regulatory fairness review[2], which is assessing how effectively the GMC looks for the risk of bias in their own systems, and how they can embed better controls to prevent biased thinking.

In 2021, the GMC also announced a new target to eliminate disproportionate complaints from employers about ethnic minority doctors. We welcome this commitment, and the range of measures they've set to help meet this target by 2026, including:

- Working with ROs in order to make workplaces more inclusive and supportive
- Developing an amended referral form to ensure organisations check a referral is appropriate before it is submitted to the GMC
- Supporting organisations to understand GMC thresholds for fitness to practise referrals to help ensure fairer outcomes.

[1] https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer

[2] https://www.gmc-uk.org/about/how-we-work/equality-diversity-and-inclusion/making-sure-our-processes-are-fair

Black and minority ethnic professional organisations including the British Association of Physicians of Indian Origin (BAPIO), the British International Doctors Association (BIDA), the Association of Pakistani Physicians of Northern Europe (APPNE) and members of the GMC's Black and Minority Ethnic Doctors Forum, have reaffirmed continuing support to the GMC in achieving their target.

The GMC's focus on induction of international medical graduates through their Welcome to UK practice programme; and their support of other initiatives including BAPIO's Dignity at Work Standards, are also welcome. As is their contribution to the development of 'Welcoming and Valuing International Medical Graduates: A guide to induction for IMGS recruited to the NHS'. This package which focuses on patient safety, professionalism, legal and ethical practice, and maintaining health and wellbeing - is an easily accessible online tool for the UK's health services. One of our recommendations for others is that doctors working for private organisations, should also be able access it.

3. *A belief that the sanction imposed against Dr Arora was too harsh, bearing in mind the low-level nature of the allegation found proven, and a perception that she was not treated with compassion during the tribunal.*

Although there has also been public criticism of the decision reached by the medical practitioners tribunal, their findings are not within the scope of this review. That is because they are independent in their decision making and operate separately from the investigatory role of the GMC.

However, to help us assess the way in which the GMC presented the case at tribunal, the Medical Practitioners Tribunal Service provided us with a transcript of Dr Arora's cross examination. We also considered comments from the profession about the trauma of giving evidence and being relentlessly challenged. We recognise that legal representatives are entitled to put their case robustly, and in some cases that will involve asserting that a witness is being untruthful. We also appreciate that this process may need to be adversarial at times, but it is important for all involved to be mindful that challenges are being made in the course of an inquiry, not a criminal trial. They should be made politely, firmly but without discourtesy. In setting out our views on the importance of compassion in regulatory processes, we imply no criticism of counsel or the tribunal chair in Dr Arora's hearing.

We conclude that the GMC's policies and processes at every stage of a fitness to practise case, up to and including a tribunal hearing, should emphasise that everyone involved is treated with both compassion and respect.

Our recommendations directly reflect these findings and how stressful the fitness to practise process can be for doctors who have had a concern raised about them. We firmly believe it is important for all relevant individuals and organisations - ROs, medical defence and representative organisations, and the GMC - to provide doctors with support for the duration of a concern, and beyond the tribunal hearing.

## Our recommendations

Our recommendations for the GMC are grouped under each stage of the fitness to practise process set out in our terms of reference.

During our review we also took the opportunity to consider the role of compassion and cultural competence in professional healthcare regulation, and the GMC's ongoing work on regulatory fairness. In exploring these areas, we have made some additional recommendations that we believe can contribute to the GMC's learning and continuous improvement of their processes and policies.

Where we think it would be helpful for other organisations, or parts of the UK's healthcare system, to consider their contribution to regulation, and to the development of more supportive and inclusive environments, we have also made recommendations for them to consider.

In setting out our recommendations, we provide contextual information where we're able to do so. As Dr Arora has no fitness to practise findings on her registration, we have taken care to ensure her confidentiality, and the confidentiality of others involved. To support a culture of learning, wherever possible, we refer to 'the GMC', rather than specific individuals or teams.

### The referral into the GMC

Concerns about a doctor can arrive into the GMC in a number of ways. As well as examining how the GMC dealt with this referral, we also considered how the allegations about Dr Arora were handled before they reached the regulator.

Doctors practising in the UK's health services, including Dr Arora, have a responsible officer (RO), who is accountable for local clinical governance processes, with a focus on the conduct and performance of doctors.[3]

We found no evidence to suggest that the GMC advised the referrer to consider raising their concerns with Dr Arora's RO in the first instance. We believe the GMC should have done this. However, this should not be seen as a criticism of the referrer's action in this specific case. We recommend that the GMC embeds a culture where referrers are encouraged to seek and feel responsible for a local first solution.

[3] https://www.england.nhs.uk/professional-standards/medical-revalidation/ro/ro-faqs/

**Recommendation**

1. It is always best practice, in cases where there is no immediate risk to patient safety for concerns to be raised either with one of the GMC's Employer Liaison Advisers (ELA), where available, or an RO. This allows for attention to be focussed on live concerns and presents an opportunity for matters to be resolved locally. On receipt of an employer referral, the GMC should ask whether efforts have been made to liaise with the RO and, if not, encourage the referrer to consult with them before taking any further action (excluding immediate patient safety concerns). They should also consider further amending their referral form to include a requirement for the referrer to discuss with the relevant RO first. To aid with this recommendation, the GMC should consider updating their triage guidance, to guide a referrer to a local first approach via an RO, if that hasn't already happened; and before a decision is made on whether to promote a referral to investigation.

We also believe that others have an important role to play in this space and we have suggested recommendations for others to reflect this.

**Recommendations**

2. The UK's health services and the GMC should collaborate to promote a local resolution first culture; and explore whether additional training on complaints handling and investigations at a local level would be beneficial. The GMC should also encourage the Care Quality Commission to include the assessment of complaints handling as a part of their 'well led' inspection framework.
3. Trusts and boards across the UK should consider using a digital system to share good practice in the local resolution and handling of complaints, as a means of learning and continuous improvement.

*To note*

At this stage of the review, we also considered information sharing between employers, who are not working within designated bodies, and responsible officers.

The referral in this case came from the organisation who employed Dr Arora. This organisation is not a designated body, which means they did not have a GMC ELA. The GMC has told us that their ELAs work with designated bodies to address concerns about doctors and support the management of concerns at a local level; and that over time, this regular engagement has streamlined referrals into the GMC. In turn this has enabled serious concerns to be raised more swiftly and reduced the referral of less serious cases.

In 2019, the GMC published Dr Doyin Atewologun and Roger Kline's 'Fair to Refer?' research which they commissioned to better understand why employers are more likely to refer some groups of doctors to the GMC. In response to the findings the GMC updated their referral form to include

specific questions designed to confirm that the referrer has liaised with the relevant RO in advance. ROs now also have to confirm the steps they've taken to ensure the referral is fair. In addition, the GMC updated their referral guidance for ROs in 2021, which makes it clear that ROs should seek advice from their ELA when concerns arise and before making a referral, unless delaying the referral would present an imminent risk to patient safety.[4]

### The decision to promote the investigation

When considering a referral, the GMC carries out an initial assessment of the information they've received to determine whether it needs to be investigated further. The test they apply at this stage is if the allegation appears to raise a question as to whether fitness to practise is impaired.

Section 35C(2) of the Medical Act 1983 as amended states that a doctor's fitness to practise can be impaired by any or all of the following:

- misconduct
- deficient professional performance
- a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales)
- adverse physical or mental health
- not having the necessary knowledge of English
- a determination (decision) by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.

In Dr Arora's case, the referral was promoted for investigation. We have looked at all the relevant documentation, including the referral itself and the reasons given for promoting it to investigation. We found that the basis for promotion was sufficiently detailed, that it referenced the relevant section of the Medical Act, and that it highlighted potential relevant concerns. Therefore, it would not have been appropriate to close the referral at this stage without further enquiry.

We also assessed the GMC's investigation plan and found that all relevant sections had been completed in line with its own guidance. However, their guidance is mainly centred around enabling case progression via milestones and establishing timelines for activity as a means of avoiding case drift. It does not encourage the identification of aims and priorities - which we believe would have been helpful in Dr Arora's case. Providing clarity about the purpose and scope of an investigation from the outset can help ensure the GMC only take forward allegations which meet the appropriate threshold. It can also improve communication between all those involved,

[4] https://www.gmc-uk.org/-/media/documents/dc9089-referal-guidance_pdf-66767403.pdf

including those who have had a concern raised about them, the GMC, and the referrer. In turn, this can aid understanding of, and manage expectations about, a case's potential pathway.

We recommend that these plans are seen and used as important tools for focused and efficient investigations. And, linked to our findings at the referral stage, that plans should also be used to explore and document how allegations are handled before they reach the regulator.

**Recommendation**

4. The GMC should review their investigation plan guidance to consider whether it should be expanded to say more about the aims, priorities and scope of an investigation; and what considerations should be recorded if a concern has already been the subject of a local investigation, before being referred to the GMC.

*To note*

When we looked at this stage of the process, we observed that it began in the early months of the pandemic and first UK-wide lockdown in 2020. At this time, many of the GMC's internal systems and processes - specifically those related to gathering witness statements or disclosure of documents from healthcare organisations - were initially paused or operating differently, so as not to place an additional burden on those who were responsible for frontline care. The impact of this is evident in early communications about progressing this case.

Since the decision to promote Dr Arora's case in early 2020, the GMC has done more to foster a culture of questioning referrals if there's a belief that they may have been submitted prematurely. This is good practice, and we fully support this more collaborative approach which will ensure that only those cases that meet the required threshold are accepted into the GMC.

### The point at which allegations are put to a doctor for their response (Rule 7)

Rule 7 of the GMC's Fitness to Practise Rules (2004), states that the GMC will investigate cases to assess whether they should be referred to a medical practitioners tribunal, and that as part of this process they may seek comments from the doctor under investigation. The GMC's Rule 7 correspondence sets out the matters that appear to raise a question about the doctor's fitness to practise; and includes relevant documentation that they've received in support of the allegation(s). They invite the doctor to respond to this letter, within 28 days.

The GMC's guidance for this correspondence, says that only those matters which are serious enough to justify the allegation should be included; and that unnecessary and oppressive charges should be avoided.

In considering Dr Arora's case, we found that there were misgivings within the GMC about some of the allegations in the Rule 7 correspondence, including whether they amounted to serious misconduct. We agree with these

misgivings. Our recommendations reflect the approach we believe should have happened at the time. If a wider discussion about the allegations and merits of the case had taken place at an appropriate level, other potential issues may have been explored in more detail, including points subsequently raised in Dr Arora's defence.

**Recommendation**

5. The GMC should do more to embed a culture of professional curiosity, where individuals in all relevant teams actively seek to add value by raising queries about the evidence provided, and where potential concerns are flagged at the earliest opportunity. To aid with this, the GMC should consider developing an escalation policy and process, to ensure that concerns about cases are raised at the right level(s) until appropriately resolved.

## The case examiner decision

At the end of an investigation there are a number of options open to the GMC. They can:

- refer the case to a medical practitioners tribunal
- agree undertakings
- offer a warning (or refer the matter to the Investigation Committee for a hearing regarding whether to issue a warning)
- conclude the case with no further action.

The decision is taken unanimously by a medical and a lay case examiner, by applying the following tests:

- are the allegations serious enough to warrant action on the doctor's registration (seriousness)?
- are the allegations capable of proof to the required standard, namely that it is more likely than not that the alleged events occurred (realistic prospect)?

Before assessing the GMC's decision making, we again looked at the evidence they held about the allegations, and at relevant internal advice. This included the GMC's guidance for case examiners on allegations of low level violence and dishonesty[5].

In considering this stage of Dr Arora's case, we recognise that there are challenges in evaluating decision making. It is perfectly acceptable for individual decision makers to reach different conclusions on the same evidence, and on the application of the same legal principles or guidance.

[5] https://www.gmc-uk.org/-/media/documents/dc13478-guidance-for-decision-makers-on-allegations-of-low-level-violence-and-dishonesty----85755346.pdf

Bearing in mind the high-profile criticism of the GMC in the aftermath of this case, together with the GMC's decision not to contest Dr Arora's appeal, it would be easy to assume that their decision making was wrong. However, our job was to determine whether the decisions they made were within a range of reasonable decisions. Even if we may have reached a different decision faced with the same evidence, and applying the same tests and guidance, it doesn't automatically mean that they made a mistake.

That is why some of our recommendations in this area particularly focus on the importance of clearly articulated, reasoned, and well-evidenced written decisions, that fully address all relevant tests and objectives. When we considered the documentation in this case, we found that some decisions would have benefitted from more detailed explanation and supporting information. In addition, we recommend that the GMC should consider whether their guidance for decision makers enables flexible and proportionate decision making.

We also assessed whether the GMC had correctly applied relevant thresholds and legal tests in their decision making. We specifically looked at how the GMC applied the objective legal test for dishonesty, as laid down in Ivey v Genting Casinos Ltd t/a Crockfords, when they considered an allegation related to Dr Arora's probity. This required the GMC to be satisfied that 'ordinary decent people' would describe this allegation as dishonest; and that embellishment or exaggeration in and of itself does not necessarily equate to dishonesty. We found that the GMC incorrectly applied the legal test when considering this particular allegation. They were therefore wrong to conclude that Dr Arora's actions could be said to be objectively dishonest, taking account of the whole of the circumstances. As such, it should not have been taken forward.

We examined decisions about other allegations in this case, including one which was taken forward to tribunal. On the latter, while the written decision could have been better articulated and reasoned, we found that it was capable of meeting the threshold for seriousness, and that it met the realistic prospect test.

We hope our recommendations in this area will help build confidence in the GMC's decision making over time.

**Recommendations**

6. The GMC should ensure that all decisions are set out in full and include reference to the seriousness of the allegation(s) and the realistic prospect test. They should include a robust analysis of all of the available evidence, rather than a summary.
7. The GMC should consider whether their low level violence and dishonesty guidance gives those making decisions enough flexibility; and/ or whether supporting information should be provided to decision makers to ensure they fully understand the discretion they have in each case in order to make the right decision.
8. The GMC should consider expanding their existing internal review process across all relevant teams; this should include identification of issues and good practice in case handling; and through post-case discussions, looking at successful and unsuccessful outcomes, to drive continuous improvement.

### The legal team's input, including instructions to counsel, and counsel's input before the tribunal hearing; and the presentation of the GMC's case at the tribunal hearing

Once the GMC has referred a case to the medical practitioners tribunal, they instruct counsel to present their case at a hearing. The GMC instructs from a pool of barristers who have experience of their work to ensure consistency and quality of representation.

In preparation for the hearing, the GMC prepares the final charges, known as the Rule 15 allegations. Once these have been agreed within the GMC, they are sent to counsel.

On examining these materials, we found that that the GMC had not specifically asked counsel to advise them of the overall merits of their case, although they'd asked whether any evidence would strengthen it. We believe this was a missed opportunity, and that part of counsel's role should be to consider evidential sufficiency. This includes raising any concerns they have about the merits of any one of the allegations before them, or the case as a whole. Our recommendations reflect this finding.

Shortly before a hearing commences, the GMC prepares a sanction submission. This formally records the basis for their position on the appropriate sanction before the tribunal, and evidences what they've taken into consideration when coming to that position.

We have carefully considered the submission for Dr Arora's case. While the length of submissions will vary from case to case, we conclude that on this occasion it did not include all the information we would have expected to see. Despite this, we found good practice in how it had been drafted and in the approval process. As a means of seeking to eliminate any suggestion of bias, Dr Arora's name had been removed from the submission, and it had

been drafted in gender neutral language. The process of approval was also anonymised and conducted by an individual who had not been directly involved in the case.

We have also explored how the GMC prepared for the tribunal, including their interactions with key witnesses and the referrer. We believe the GMC could and should have done more to update the referrer in advance of the hearing to ensure they were aware of the scope of the tribunal, and the allegations that the GMC were taking forward. Because this wasn't effectively communicated, the referrer felt that the GMC had misunderstood the reasons for the original referral. The referrer has since expressed concerns about the significant impact of the tribunal's determination and resulting media coverage on individuals linked to the case. With that in mind, we have made recommendations for specific process and guidance changes that will lead to improvements in the GMC's communication and engagement in future cases.

In addition, we have looked at how the GMC presented this case at the tribunal and have read the transcript from the hearing. We recognise that legal representatives are entitled to put their case robustly, and in some cases that will involve asserting that a witness is being untruthful. We also appreciate that this process may need to be adversarial at times, but we believe it is important for all involved to be mindful that challenges are being made in the course of an inquiry, not a criminal trial. They should be made politely, firmly but without discourtesy. In setting out our views here, we imply no criticism of counsel or the tribunal chair in Dr Arora's hearing. But we recommend that the GMC's policies and processes at every stage of a fitness to practise case, up to and including a tribunal hearing, should emphasise that every individual involved should be treated with both compassion and respect.

When considering all the decision points in this case, including at the tribunal stage, we conclude that there were multiple missed opportunities for the GMC to stand back and look again. There were moments where people expressed misgivings about the strength of the evidence, and whether the allegations were sufficiently serious for the GMC to become involved. Those opportunities were not pursued because it was felt unlikely to make a difference.

We fundamentally believe that it is important for every individual to add value to the process at each stage, including external counsel. This is reflected in our recommendations, which include that the GMC should do more to embed a culture of professional curiosity, including cultural curiosity, across all relevant teams; and that speaking up should be encouraged and enabled through the GMC's processes, policies and guidance.

**Recommendations**

9. The GMC should consider reviewing their guidance on the process for drafting sanction submissions, to ensure that submissions include the necessary evidence for informed decision making; to reflect that approval for some submissions may be withdrawn in the event only some of the allegations are proven; and to ensure that those who approve submissions are consulted in advance of a sanction hearing, in the event that only some of the allegations are proven.
10. Where a referrer is also a key witness in tribunal proceedings, the GMC should provide them with full details of the allegations they are taking forward.
11. When the GMC provides a witness with a redacted statement, they should draw attention to any changes that have been made, to allow an opportunity for questions or issues to be addressed in advance of the hearing.
12. When the GMC instructs external counsel, they should always ask them to consider the overall merits of the case, and to raise any concerns as soon as they become aware of them. They should also ensure they have an understanding of, and commitment to, the GMC's aim of compassionate professional healthcare regulation.

## Professional healthcare regulation for the future

As we've already noted, the profession raised a number of concerns about the GMC's handling Dr Arora's case. In our terms of reference for this review (Annex A), the GMC itself says:

> *"We have heard strong views expressed by the profession about this case. As a regulator it is absolutely right that our decisions are open to scrutiny, and we believe there is always room to improve the way that we carry out our duties."*

We have carried out our review in this spirit, with a focus on learning and continuous improvement for the future.

During this process, we also took the opportunity to consider a range of broader issues that we believe to be relevant to professional healthcare regulation in the 21st century. These include the growing diversity of the medical workforce, and the role of compassion and cultural competence in the UK's health services and professional regulation.

While these areas are not within our terms of reference, we hope that our observations and related recommendations can positively contribute to the GMC's commitment to learn and improve how they carry out their regulatory responsibilities. Where we think it would be helpful for other organisations or parts of the UK's healthcare system to consider their contribution to regulation, and to the development of more supportive and inclusive

environments, we have also suggested recommendations for them to consider.

### Our views on communication; fairness, equality and bias; and cultural competence and diversity intelligence

The UK's health services have an ethnically diverse workforce. Over 42% of doctors on the medical register are from an ethnic minority background[6]. It is vital that their contributions are valued and respected, and that they are treated fairly and equally throughout every stage of local and system regulatory processes.

While it is important, and welcome, that the GMC has set targets to eliminate the disproportionate pattern of fitness to practise complaints they receive from employers, they also need to embed equality and fairness into their processes to ensure that outcomes are fair, equitable and non-discriminatory.

Organisations leading on equality and inclusion need to go further than just saying they don't discriminate, by actively promoting equality and inclusion. The GMC's Chair, Professor Dame Carrie McEwan, has said:[7]

> *"Let's be clear: we've committed to these measures because they are absolutely the right thing to do. It's unacceptable that any doctor's ethnicity or any other protected characteristic affects how they are treated in the workplace and their ability to progress and work to their maximum capacity.*
>
> *These targets are also vital for a better, more effective and sustainable NHS workforce. We need a health service that recognises the contribution made by everyone and supports and values all doctors and their wellbeing – if the NHS doesn't do that, it simply won't be able to retain the doctors it needs."*

We therefore welcome the changes the GMC has already made to their referral process. ROs now have to confirm:

- whether any environmental pressures or systemic issues might have contributed to the concern
- where the doctor qualified overseas, what, if any, induction was provided on how to respond to concerns
- what support has been offered to help a doctor improve their understanding and knowledge since the concerns were identified
- what impartial checks they've made to ensure the referral is fair.

---

[6] The state of medical education and practice in the UK: The workforce report 2022 (gmc-uk.org)

[7] https://www.gmc-uk.org/news/news-archive/whats-next-for-the-nhs-support-compassion-and-a-sustainable-workforce

Organisations aspiring to be leaders on diversity need to normalise data-driven decision making, creating a culture that encourages critical thinking and curiosity. As in medicine, data collection for diversity is a specialised process. Researchers create and implement measures to ensure that collected data is credible and valid, and the analytical findings take account of case mix and other variable factors. When establishing processes for monitoring data, especially of teams, there is a need for strong messaging and communication that avoids apprehension or resistance, and embraces learning and improving.

The GMC and Medical Practitioners Tribunal Service sanctions guidance[8] mentions the need for understanding cross cultural communication and how different cultures may express views and behaviours including insight. In our examination of Dr Arora's case, we were disappointed to note that consideration of culture and language wasn't explicitly documented at any stage of the fitness to practise process. This is despite these being mentioned in Dr Arora's initial response to the allegations when they were put to her in the GMC's Rule 7 communication.

In raising this, we are not advocating for lesser or different standards of medical practice related to cultural difference. However, we stress that it is important to recognise differences, particularly in issues relating to communication including:

- the subtleties and nuances of a second language
- difference in relation to attitudes and behaviours
- understanding of different ways of expressing insight.

It is equally important for medical practitioner tribunal members to have a degree of cultural intelligence and cultural competence to understand these differences and reflect them in their decision making.

Language is part of culture. A person's culture is also a part of the language they use to speak and express themselves. Both are inextricably linked. Having a good level of competency or fluency in a language can never replicate the depth of understanding held by a native speaker. Language, both verbal and non-verbal, is the way in which individuals from a specific culture communicate with one another. Where communication happens between individuals from the same culture, both using the same native language, there is much less chance of misunderstanding.

Conversely in communications using a common language where one speaker is using their native tongue and the other a foreign language, there is more potential for misunderstandings and miscommunication. This is because communication through language is not solely down to the expression of particular words and phrases. It includes differences in pronunciation,

[8] https://www.gmc-uk.org/-/media/documents/DC4198_Sanctions_Guidance_Feb_2018_23008260.pdf, paragraph 48

vocabulary, rhythm, tempo and pitch at which the words are spoken. In addition, the use of accents and dialects can create difficulties for non-native speakers, even for those who are fluent with a wide vocabulary. Moreover, non-verbal forms of communication, which can be very different from one culture to another, have the potential to cause further problems. What may be considered acceptable and 'normal' in one culture, might be classed as unacceptable or rude in another, and these differences can lead to misunderstandings.

Cultural competency is as important as mastering any language. To have a deep understanding of the way in which individuals from a different culture perceive the world from their perspective, hold certain views and opinions, and behave in a specific manner helps break down barriers and prevent misunderstandings. Individuals from non-native cultures who speak a different native language from the one used every day where they live and work, can have a totally different frame of reference for what they see as normal and socially acceptable. This can potentially lead to mistakes and miscommunication and misunderstandings can, and do, occur.

Cultural Intelligence (CQ) is the ability to understand and deliver fairness and equality while considering cultural diversity. It includes CQ Drive, the ability to overcome explicit or unconscious bias, and the capacity to persist in challenging interactions. CQ Knowledge helps individuals to understand cultures and cultural differences which maybe invisible; and hidden cultural values including assumptions and beliefs. CQ Strategy helps individuals to flex mentally and integrate ideas; and CQ Action helps individuals to understand verbal and non-verbal behaviours such as body language.

Biases arise out of our need as human beings to make sense of the world by categorising ourselves and others. Two of the essential components of bias formation are categorisation and identification. The third element is comparison. Not only do we feel the need to categorise ourselves and others and identify with people who are 'like us', we also compare people like us with people who are not like us.

There are special skills needed to be aware of the risk of bias, especially racial bias in investigations which require specific training and support. Diversity Intelligence is the capability of individuals to be able to use this to guide their thinking and behaviour and complement CQ. Cognitive diversity helps understand differences in perspectives, insight, experience and thinking styles. The GMC should consider developing a programme of training and leadership messaging, and frameworks, which can be used to review practice as part of their work to ensure their decision-making processes are fair, consistent and free from bias. We recommend the GMC embeds a culture of understanding in relation to cultural awareness and sensitivity, and that CQ and cultural competence are built into its processes.

**Recommendations**

13. The GMC should ensure advice from internal or external experts and/ or training is available to relevant teams on issues linked to a doctor's communication, attitude and/ or behaviours; cultural awareness, competence and sensitivity; diversity intelligence; and eliminating bias in fitness to practise decision making.
14. The GMC and MPTS should consider whether their sanctions guidance should take greater account of the changing demographics of the medical workforce. This includes whether it should demonstrate sensitivity to the interpretation of values, cross cultures, and communication, through the lens of culture competence and diversity intelligence.
15. The GMC should consider how it assures itself that its decision making is fair and unbiased, and whether the systems and processes already in place are appropriate. This includes proactive monitoring for ethnicity related variations in teams and developing frameworks to review practice. Given the small numbers involved, case mix considerations, and risk of confounding, analyses should be used as a tool for internal continuous improvement and interpreted with care.

We also believe that others can make an important contribution in this area.

**Recommendation**

16. All partners involved in developing the 'Welcoming and Valuing International Medical Graduates: A guide to induction for IMGS recruited to the NHS', including the GMC, should encourage induction programmes to be made available to all IMGs, including those working outside the NHS. Induction should cover patient safety, professionalism, legal and ethical aspects and inform and make IMGs new to UK aware that NHS basic indemnity does not cover legal advice and support for other processes including GMC or Coroner investigations.

## Our views on compassion and support

The fundamental principles of compassion, dignity and respect are the bedrock which need to be embedded in all aspects of professional healthcare regulation.

The GMC's core guidance for doctors, *Good medical practice*[9], says that all patients should be treated with dignity and respect. In turn, they have a right to expect their regulator and its fitness to practise processes, to treat them in the same way.

Some doctors who are not sanctioned after going through the GMC's fitness to practise process, including those who were referred to a medical

[9] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

practitioner tribunal hearing, may return to practise immediately. Others may return after a period of time. But the trauma they may experience after cross-examination may last longer. We recognise that this process may need to be adversarial at times, but proceedings are supposed to be primarily inquisitorial and should not be perceived to be threatening. The GMC's policies and processes should recognise that everyone involved in their processes should be treated with both compassion and respect.

During our review, we considered comments from witnesses and doctors about the trauma that can be caused by giving evidence and being relentlessly challenged. Of course, legal representatives are entitled to put their case robustly, and in some cases that will involve asserting that a witness is being untruthful. However, it is important for all involved to be mindful that challenges are being made in the course of an inquiry, not a criminal trial. They should be made politely, firmly but without discourtesy. Best practice requires the tribunal Chairs to intervene if, as sometimes happens, matters become combative and appear personal, or if any party is not engaging with the forensic process. While we raise our views for future consideration, we have read the transcript of Dr Arora's tribunal hearing and we are not implying criticism of the counsel or the Chair in this case.

Professor Dame Carrie McEwan, Chair of the GMC has said that compassionate leadership and safe, supportive working environments are absolutely vital - not only to the welfare of doctors, but also to the future of the NHS and to the safety of patients[10]. We recognise the GMC's core values embody compassion, and the Medical Practitioners Tribunal Service promises compassion throughout a doctors contact with the organisation. We hope our recommendations will help the GMC and others across the healthcare system, to retain this focus, and consider what more they could or should do in this area in the future.

GMC fitness to practise processes can be lengthy, and regardless of the outcome, they can be traumatic and have huge repercussions for those under investigation. Professor Louis Appleby in his report for the GMC[11] concluded that doctors under investigation can feel trapped, humiliated and unjustly treated. A survey by the Medical Protection Society[12] also found that 72% of doctors investigated felt that the investigation had a detrimental impact to their mental and physical health. The UK government's reform of legislation that underpins the regulation of healthcare professionals would give the GMC greater scope for disposing of fitness to practise cases

[10] https://www.gmc-uk.org/news/news-archive/whats-next-for-the-nhs-support-compassion-and-a-sustainable-workforce
[11] https://www.gmc-uk.org/-/media/documents/internal-review-into-suicide-in-ftp-processes_pdf-59088696.pdf
[12] https://www.medicalprotection.org/uk/articles/mps-survey-gmc-investigations-impact-on-the-health-of-72-of-doctors#:~:text=A%20Medical%20Protection%20Society%20(MPS,mental%20and%2For%20physical%20health.oli.xelht.nhs.uk/sorce/beacon/?pageid=home

consensually. In turn we believe that this would enable the GMC to be more flexible, proportionate, and compassionate.

The GMC already commissions the British Medical Association to deliver an independent support service to provide doctors with up to six hours of support virtually initially, and one day of support with physical presence at the start of a tribunal hearing, if required. Medical defence organisations also have a huge responsibility to offer support. Professional organisations, including those who represent black and minority ethnic doctors, and the Centre for Remediation, Support and Training[13] also provide assistance. In looking at this case, we saw good practice in signposting, in that the GMC has added information to their staff email signatures to direct doctors to support that is available. As with our recommendations to enable compassion, we encourage all those involved in supporting doctors, to consider whether they could or should do more.

**Recommendation**

17. The GMC should consider whether the level of support they offer to doctors in a fitness to practice process is sufficient. They should also encourage medical defence organisations to improve the support they provide to doctors going through a fitness to practice process and extending to a period beyond the tribunal hearing; and responsible officers to ensure local pastoral support.

We also recognise and support the GMC's calls for reform of their legislation to enable greater flexibility within the fitness to practise process.

**Recommendation**

18. The UK government should bring forward legislative reform for the regulation of healthcare professionals at the earliest opportunity. This would enable our recommendations of compassionate, supportive, fair and proportionate regulation, by allowing the GMC to dispose of appropriate fitness to practise cases consensually.

## Conclusion

The GMC asked us to co-chair this review to identify whether there were lessons to learn from their handling of Dr Arora's case that can be applied to future cases.

Our terms of reference acknowledge the strong views expressed by the profession about this case. They include concerns about fairness and the perception of unequal treatment of black and minority ethnic doctors in regulatory processes; and a belief that the decision itself and the decision-making process was directly affected by Dr Arora's ethnicity. We also subsequently received feedback about the importance of local resolution

[13] Centre for Remediation, Support and Training | University of Bolton

and proportionate regulation in light of feelings that the sanction imposed on Dr Arora was too harsh.

We have kept these views at the forefront of our minds throughout our deliberations on this case; along with the GMC's core role to protect patients in all four countries of the UK.

We recognise that regulators, including the GMC, do not measure success by how many complaints they handle or how many sanctions they apply; but how, over a period of time, they have brought about improvements in standards, and prevented complaints from reaching the final stages.

The GMC's Outreach team, through their ELAs, already support individual trusts and boards across the UK by promoting and supporting local resolution of fitness to practise cases. In many cases, advice or warnings are the most appropriate sanction, which is why we have used our recommendations to encourage the GMC to consider what more they can do, with others, to embed a local first culture. We also welcome the GMC's efforts to deliver training on their ethical and professional guidance to thousands of medical students and doctors every year; along with their continued investment in their Welcome to UK practice programme for international medical graduates who are joining the UK's health services.

In carrying out our review, we have also considered the GMC's ongoing work on equality and fairness, including their targets for eliminating disproportionate fitness to practise referrals. We recognise the leadership shown by the GMC's Chair and Chief Executive in this area, but joint effort and partnership working across the UK's health systems are required for change to be meaningful and long lasting. Where we have made recommendations for others, we ask that they seriously consider implementing and supporting them. We also reiterate our call for the GMC to maintain its focus on seeking out bias in their processes, rather than looking for assurance that it does not exist. We believe our findings and recommendations will support the GMC to consider whether their systems and processes for checking fairness, consistency and bias in decision making, are appropriate.

The UK government's reform of legislation that underpins the regulation of healthcare professionals is long awaited and is vital for a more flexible, proportionate, and compassionate approach to fitness to practise in the future. We join the GMC in calling for these reforms, which we believe should happen as quickly as possible, for the benefit of both doctors and patients.

Finally, we would like to reiterate our belief that compassion should be a key component of regulatory processes. The medical profession rose to the challenge to deliver during the pandemic - as we recover and reset it is very important that we support doctors both in their working lives, and in any contact with their regulator. We ask the GMC to monitor, evaluate and report progress on our recommendations. We also sincerely hope that our review will help to bring some closure for Dr Arora.

# Annex A

## The terms of reference set out by the GMC for this review

### *About the review*

To carry out a review of Dr Manjula Arora's case to understand whether there are lessons to learn and apply in future cases.

### *Background*

In February 2020, Dr Arora's employer raised concerns to the GMC. Following an investigation, we referred two matters to a medical practitioners tribunal. The tribunal found one matter, relating to dishonesty, was proved; that Dr Arora's fitness to practise was impaired, and that she should be suspended for one month.

We have heard strong views expressed by the profession about this case. As a regulator it is absolutely right that our decisions are open to scrutiny, and we believe there is always room to improve the way that we carry out our duties. Our Chief Executive, Charlie Massey, asked for a review of this case to understand whether there are lessons to learn and apply for future cases.

### *The role of external oversight*

Professor Iqbal Singh CBE and Martin Forde QC will oversee the review. Their role includes:

- advising on the scope of the review, and appropriate lines of enquiry
- reviewing information gathered from files, fieldwork, and interviews; and ensuring progress to agreed milestones
- reviewing the draft findings and scrutinising conclusions and recommendations.

Professor Iqbal Singh CBE is a hugely experienced consultant clinician specialising in care of the elderly. He is a dedicated pioneer in ethnic health and diversity and is Chair of the GMC's BME Doctors Forum. He is also Chair of the Centre of Excellence in Safety for Older People and the Centre for Remediation and Support.

Martin Forde QC's practice covers all aspects of health law. His recent work also includes leading the independent investigation into a report into antisemitism within the Labour Party in 2020; and acting as the independent adviser to the Windrush Compensation Scheme from 2018 to 2021.

### *Scope*

The following areas are within scope of the review:

- The referral into the GMC
- The decision to promote the investigation
- The point at which allegations are put to a doctor for their response (Rule 7)

- The case examiner decision
- The legal team's input, including instructions to counsel, and counsel's input before the tribunal hearing
- The presentation of the GMC's case at the tribunal hearing
- Information sharing between employers, who are not working within designated bodies, and Responsible Officers.

*The following areas are not within scope of the review:*

- The tribunal's determination in this case
- The GMC's position on Dr Arora's appeal against the tribunal's determination
- Consideration of the GMC's existing guidance, policies, and processes.

*Approach*

| Stage | Activity |
|---|---|
| **1** | Scope and terms of reference agreed |
| **2** | Fieldwork: review of file and supporting information, including<br>1. the referral<br>2. details of the investigation process<br>3. the case examiner decision<br>4. instructions to counsel<br>Conducting interviews |
| **3** | Develop draft findings, conclusions and recommendations |
| **4** | Quality assurance and scrutiny |
| **5** | Report finalised and submitted to Chief Executive and Chair |
| **6** | Publication of review's findings, conclusions and recommendations |

*Governance*

Dr Arora's case is not subject to a formal Significant Event Review. It therefore won't automatically go before the GMC's Audit and Risk Committee.

However, we will ask the Committee to consider the report to facilitate scrutiny and provide assurance to our Council.

### *Sharing the findings*

We take the feedback we've heard about this case extremely seriously. We will complete this review as swiftly as possible. We will share the findings will the profession and stakeholders by publishing it on our website. And if the review identifies learnings, we will implement them.

## Annex B

### Recommendations for the GMC and others

| Number | Recommendation |
|---|---|
| **1** | It is always best practice, in cases where there is no immediate risk to patient safety for concerns to be raised either with one of the GMC's Employer Liaison Advisers (ELA), where available, or a responsible officer (RO). This allows for attention to be focussed on live concerns and presents an opportunity for matters to be resolved locally. On receipt of an employer referral, the GMC should ask whether efforts have been made to liaise with the RO and, if not, encourage the referrer to consult with them before taking any further action (excluding immediate patient safety concerns). They should also consider further amending their referral form to include a requirement for the referrer to discuss with the relevant RO first. To aid with this recommendation, the GMC should consider updating their triage guidance, to guide a referrer to a local first approach via an RO, if that hasn't already happened; and before a decision is made on whether to promote a referral to investigation. |
| **2** | The UK's health services, and the GMC, should collaborate to promote a local resolution first culture; and explore whether additional training on complaints handling and investigations at a local level would be beneficial. The GMC should also encourage the Care Quality Commission to include the assessment of complaints handling as a part of their 'well led' inspection framework. |
| **3** | Trusts and boards across the UK should consider using a digital system to share good practice in the local resolution and handling of complaints, as a means of learning and continuous improvement. |
| **4** | The GMC should review their investigation plan guidance to consider whether it should be expanded to say more about the aims, priorities and scope of an investigation; and what considerations should be recorded if a concern has already been the subject of a local investigation, before being referred to the GMC. |

| Number | Recommendation |
|---|---|
| **5** | The GMC should do more to embed a culture of professional curiosity, where individuals in all relevant teams actively seek to add value by raising queries about the evidence provided, and where potential concerns are flagged at the earliest opportunity. To aid with this, the GMC should consider developing an escalation policy and process, to ensure that concerns about cases are raised at the right level(s) until appropriately resolved. |
| **6** | The GMC should ensure that all decisions are set out in full and include reference to the seriousness of the allegation(s) and the realistic prospect test. They should include a robust analysis of all of the available evidence, rather than a summary. |
| **7** | The GMC should consider whether their low level violence and dishonesty guidance gives those making decisions enough flexibility; and/ or whether supporting information should be provided to decision makers to ensure they fully understand the discretion they have in each case in order to make the right decision. |
| **8** | The GMC should consider expanding their existing internal review process across all relevant teams; this should include identification of issues and good practice in case handling; and through post-case discussions, looking at successful and unsuccessful outcomes, to drive continuous improvement. |
| **9** | The GMC should consider reviewing their guidance on the process for drafting sanction submissions, to ensure that submissions include the necessary evidence for informed decision making; to reflect that approval for some submissions may be withdrawn in the event only some of the allegations are proven; and to ensure that those who approve submissions are consulted in advance of a sanction hearing, in the event that only some of the allegations are proven. |
| **10** | Where a referrer is also a key witness in tribunal proceedings, the GMC should provide them with full details of the allegations they are taking forward. |

| Number | Recommendation |
|---|---|
| **11** | When the GMC provides a witness with a redacted statement, they should draw attention to any changes that have been made, to allow an opportunity for questions or issues to be addressed in advance of the hearing. |
| **12** | When the GMC instructs external counsel, they should always ask them to consider the overall merits of the case, and to raise any concerns as soon as they become aware of them. They should also ensure they have an understanding of, and commitment to, the GMC's aim of compassionate professional healthcare regulation. |
| **13** | The GMC should ensure advice from internal or external experts and/ or training is available to relevant teams on issues linked to a doctor's communication, attitude and/ or behaviours; cultural awareness, competence and sensitivity; diversity intelligence; and eliminating bias in fitness to practise decision making. |
| **14** | The GMC and MPTS should consider whether their sanctions guidance should take greater account of the changing demographics of the medical workforce. This includes whether it should demonstrate sensitivity to the interpretation of values, cross cultures, and communication, through the lens of culture competence and diversity intelligence. |
| **15** | The GMC should consider how it assures itself that its decision making is fair and unbiased, and whether the systems and processes already in place are appropriate. This includes proactive monitoring for ethnicity related variations in teams and developing frameworks to review practice. Given the small numbers involved, case mix considerations, and risk of confounding, analyses should be used as a tool for internal continuous improvement and interpreted with care. |

| Number | Recommendation |
|---|---|
| **16** | All partners involved in developing the 'Welcoming and Valuing International Medical Graduates: A guide to induction for IMGS recruited to the NHS', including the GMC, should encourage induction programmes to be made available to all IMGs, including those working outside the NHS. Induction should cover patient safety, professionalism, legal and ethical aspects and inform and make IMGs new to UK aware that NHS basic indemnity does not cover legal advice and support for other processes including GMC or Coroner investigations. |
| **17** | The GMC should consider whether the level of support they offer to doctors in a fitness to practice process is sufficient. They should also encourage medical defence organisations to improve the support they provide to doctors going through a fitness to practice process and extending to a period beyond the tribunal hearing; and responsible officers to ensure local pastoral support. |
| **18** | The UK government should bring forward legislative reform for the regulation of healthcare professionals at the earliest opportunity. This would enable our recommendations of compassionate, supportive, fair and proportionate regulation, by allowing the GMC to dispose of appropriate fitness to practise cases consensually. |

To ask for this publication in another format or language, please call the GMC on 0161 923 6602 or email gmc@gmc-uk.org

Published November 2022
The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)