

## Justice Committee

### Apologies (Scotland) Act 2016 (Excepted Proceedings) Regulations 2017

#### Written submission from the General Medical Council

1. This briefing by the GMC sets out why we are seeking for our proceedings to be excepted from the application of the Apologies (Scotland) Act 2016 (the Act). Whilst many of our proceedings are similar to those of the other healthcare professional regulators, the ways in which apologies are treated are slightly different and we therefore feel it is important that we outline the role they play in the regulation of the medical profession.
2. This briefing is in addition to the standalone statement made jointly by healthcare professional regulators, setting out our common position on the need for an exception to the Act, which we have signed and fully endorse.

#### Our role

3. The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.
  - We decide which doctors are qualified to work here and we oversee UK medical education and training.
  - We set standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
  - We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.

4. Broadly, the role of apologies may impact on the following areas of our work:
  - Investigating and acting on [fitness to practise concerns about doctors](#) – As GMC fitness to practise proceedings are about protecting the public and not punishing doctors, the fact that a doctor has insight into what went wrong is a significant factor in reducing the risk that they are likely to repeat it. If a doctor has insight and is unlikely to repeat failings or concerns, we may not need to take any action.
  - An apology may act as evidence of a doctor's insight to support a doctor's submission during a GMC investigation or a Medical Practitioners Tribunal Service (MPTS) tribunal that concerns are unlikely to be repeated and that therefore GMC action is not required. Where a doctor is making submissions that they have insight, the fact that they have failed to make an apology may be raised. A range of factors can

influence whether, or how, a doctor apologises – such as fear of legal action and personal circumstances (e.g. ill health) and these would be taken into account. The presence or lack of an apology may lead a tribunal to decide whether a doctor has demonstrated insight and to consider how presence or lack of insight impacts on the risk they represent to public safety or public confidence in the medical profession.

- [Revalidation](#) – when doctors are preparing their supporting information, they are required to collect and review information on significant events. Appraisers will be interested in any actions the doctor took or any changes they implemented to prevent such events or incidents happening again.
- GMC guidance - our core guidance for doctors [Good medical practice](#), and our explanatory guidance [Openness and honesty when things go wrong- the professional duty of candour](#), set out the standards we set for doctors in terms of apologies.

We expand on these areas below.

### *Fitness to Practise Proceedings*

5. GMC/MPTS Sanctions Guidance makes clear that ‘a doctor’s apology by itself does not necessarily mean that they accept legal liability for what has happened or a breach of statutory duty’. The guidance goes on to say ‘For the purpose of [GMC] fitness to practise proceedings, an apology by itself will not be treated as an admission of guilt (whether as to facts or impairment).’ This sets out clearly the GMC’s policy that an apology, of itself, will not be used in GMC proceedings to prove allegations made against them. However, when a doctor makes an apology, they may, at the same time, provide other information that is not part of the apology that is critical to the fitness to practise proceedings and our ability to protect patients. For example, if a doctor says they are sorry for what has happened to a patient, we would not use the fact of the apology alone as evidence of impairment. However, if at the same time as they apologise, they make a clear admission that they carried out serious misconduct (this does not include general expressions of regret about the care or the outcome), that information (and not the apology) would be used to prove their actions or omissions.
6. In GMC fitness to practise proceedings, there are circumstances in which an apology could be used to a doctor’s advantage or the failure to make an apology could be used to their detriment. The apology itself, would only ever be submitted by a doctor to support their submission that they have insight and the only circumstances in which the GMC would use an apology (or lack of an apology) in itself to a doctor’s disadvantage in proceedings would be to question why a doctor who has submitted they have insight didn’t apologise, or why there was delay in making an apology (for example, not apologising until fitness to practise proceedings have commenced). Without an exception being drafted, an apology would be prevented from being considered fully in fitness to practise

proceedings, for example an apology being used as evidence of insight, or delay in providing an apology being used as evidence of lack of insight.

7. The definition of an apology at section 3 of the Act is drafted more broadly than just an expression of sorrow or regret. Under this definition, an apology may also include “an undertaking to look at circumstances giving rise to the act or omission or outcome with a view to preventing the recurrence”. In a GMC fitness to practise context, we envisage that such an “undertaking” may provide evidence of the extent to which a doctor has shown insight and remediated the relevant act or omission and such remediation evidence will be relevant to the question of whether there is an ongoing risk and whether the GMC needs to take action. Like an apology, we would not use the fact that a doctor gives an undertaking (as described at section 3) as an admission of liability (either as to facts or impairment). However, if a tribunal has already made findings about what happened, such an undertaking may be used to someone’s disadvantage if, for example, the terms of such an “undertaking” provided by a doctor about the steps to be taken to remediate/put right the matter are found by a tribunal not to be sufficient and/or appropriate in the circumstances given their findings about what happened and this may be relevant evidence which (amongst other evidence) supports a finding of impairment against the doctor. It could also be used to the doctor’s detriment, where a doctor, as part of his apology, promises to remediate, but subsequently fails to take appropriate steps to do so.
8. More information can be found in the GMC/MPTS [Sanctions Guidance](#), which sets out the relevance of an apology to a doctor’s insight/remediation in fitness to practise proceedings (see paragraphs 35 to 39).
9. Our Sanctions Guidance provides assurance that an apology in itself will not be used as evidence of liability in GMC fitness to practise proceedings. It is important that an apology is allowed to be considered (i.e. to be admissible) throughout the course of the GMC’s fitness to practise processes so that any information that does not form part of the apology, but is contained within it, and is relevant to whether the doctor poses a serious ongoing risk to the public can be considered. Also we think it important that doctors can present an apology as evidence of insight in mitigation and conversely that the GMC should be able to reference a failure to apologise as evidence of lack of insight.
10. GMC fitness to practise procedures may involve referral of a doctor to a hearing before a MPTS tribunal<sup>1</sup> or determination by other GMC decision-makers, known as Case Examiners. Some appeals and other challenges to fitness to practise decisions will be heard in the Scottish courts. The absence of an exception for regulatory proceedings under the Act would lead to inconsistency in what evidence would be admissible at different stages of fitness to practise proceedings and would ultimately affect our ability to ensure the public is protected.

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<sup>1</sup> Interim orders tribunals hear cases, and may make an order suspending a doctor's registration or imposing conditions upon a doctor's registration, whilst a GMC investigation is in progress. Medical practitioners tribunals hear evidence and decide whether a doctor's fitness to practise is impaired.

### *Registration and revalidation*

11. The GMC's processes for registration and maintaining a licence to practise medicine (known as revalidation) may result in appeals before the Scottish courts. We can potentially foresee a situation where an issue, which is the subject of a registration or revalidation appeal could relate to a matter in which an apology was given. Whilst evidence regarding the apology would be admissible before the independent registration and revalidation appeal panel in the case, should any further appeal be made and fall to be heard in the Scottish courts, unless there was an exception for regulatory proceedings, there would be an inconsistency in what would be admissible and relevant evidence in the appeal proceedings. Whilst this may be a less likely scenario than the issues we have identified about fitness to practise cases, our concerns about differences between the GMC and the Scottish courts, discrepancies in approach, potential unfairness and inconsistency in outcome are similar.

### *The professional vs the organisational duty of candour*

12. The [organisational duty of candour](#) and professional duty of candour are two separate duties, which have similarities but do not apply in entirely the same way. Therefore excepting only the organisational duty from the application of the Act would lead to inconsistencies in how apologies made in respect of the same act or omission, but provided in accordance with different duties, will be treated. We note that it is accepted that an exception is needed for the organisational duty of candour and we cannot see why the same rationale should not apply to excepting apologies made in accordance with the professional duty of candour, which is outlined below.
13. Our professional standards define what makes a good doctor by setting out the professional values, knowledge, skills and behaviours required of all registered doctors in the UK. We consult with a wide range of people, including patients, doctors, employers and educators to develop our standards and guidance.

The core professional standards expected of all doctors are set out in [Good medical practice](#) which covers fundamental aspects of a doctor's role, including working in partnership with patients and treating them with respect. We provide detailed guidance on ethical principles that most doctors will use every day, such as consent and confidentiality, and more specific guidance on a range of areas such as raising concerns about patient safety and the professional duty of candour.

14. Good medical practice outlines that when things go wrong, doctors have a duty to put matters right (if that is possible), offer an apology, and explain fully and promptly what has happened and the likely short-term and long-term effects. This professional duty is expanded on within our joint explanatory guidance, with the Nursing and Midwifery Council, '[Openness and honesty when things go wrong – the professional duty of candour](#)', which applies to every doctor, nurse and midwife in the UK. Our professional guidance and the joint GMC/NMC guidance are widely promoted including to organisations that provide support and advocacy to patients.

15. Our guidance on the professional duty is not prescriptive about the circumstances in which it applies but makes clear that it applies when something goes wrong with a patient's care, and they suffer harm or distress as a result, or in situations where a patient may yet suffer harm or distress as a result of something that has gone wrong with their care (paragraph 8).

16. The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act is more prescriptive about the circumstances in which it applies and states that the organisational duty of candour applies if an incident appears to have resulted in, or could result in, an outcome mentioned in subsection 21(4).<sup>2</sup> We would envisage situations where an act or omission may be subject to the professional duty but not the organisational duty (or vice versa).

If there is an exception for apologies made in accordance with the duty of candour procedure set out in Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act, but this is not replicated for the professional duty of candour, then it would lead to discrepancies which could have implications for the regulation of healthcare professionals, and consequently patient safety and the public's confidence in the professions.

17. As described at paragraph 5 above, we do not see complying with the professional duty by apologising to a patient as an admission of legal liability for what has happened. Nor do we expect doctors to take personal responsibility for something that wasn't their fault when apologising. We stress this in paragraphs 14 and 15 of the guidance.
18. So an exception for GMC proceedings from the application of the Act will protect patients' recourse to the professional regulator, and our ability to make fair and informed judgements about a doctor's fitness to practise, in case of any concerns about apparent non-compliance with the professional duty.

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<sup>2</sup>“(4) The outcomes are- (a) the death of the person, (b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) (“severe harm”), (c) harm which is not severe but which results in- (i) an increase in the person's treatment, (ii) changes to the structure of the person's body, (iii) the shortening of the life expectancy of the person, (iv) an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days, (v) the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days, (d) the person requiring treatment by a registered health professional in order to prevent- (i) the death of the person, or (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph (b) or (c).”

<http://www.legislation.gov.uk/asp/2016/14/section/21/enacted>