

## Professional Regulation Committee – ARM 2021 report

The Professional Regulation Committee seeks to reflect the profession's views on all aspects of professional regulation, including matters relating to GMC registration, GMC standards such as good medical practice, revalidation, referrals to the GMC and its fitness to practise processes, as well as the GMC's role in overseeing UK medical education and training. The committee works with key stakeholders to drive improvements in professional regulation, with its overarching aims to make professional regulation fairer, less burdensome, and more efficient. The Committee is overseen by its chair Professor Dame Clare Gerada and deputy-chair Dr Mark Corcoran, and is supported by the Regulation, Education and Training policy team.

A summary of the key areas the committee worked on during the 2020/21 session is provided below.

1. The committee was responsible for the BMA's comprehensive response to the Department of Health and Social Care (DHSC) *Regulating healthcare professionals, protecting the public* consultation. This significant consultation related to all 10 UK healthcare professional regulators, and covered regulator governance structures, registration, education and training, fitness to practise processes, and the regulation of physician associates and anaesthesia associates. The committee agreed with the general principles underlying many of the proposals in the consultation, such as greater regulator transparency and openness, more flexible processes, and improvements to fitness to practise processes. Importantly, it argued that the fundamental aspects of medical education and regulation should continue to be set out in legislation (including the CCT and licence to practise) and called for greater representation for registrants within regulators' decision-making structures.
2. Although the BMA is opposed to the GMC regulating non-doctors, the committee constructively engaged with the GMC to ensure its proposals for the future regulation of Physician Associates and Anaesthesia Associates do not negatively impact doctors. As part of this work, the committee directly challenged the GMC's collective description of doctors, PAs, and AAs as medical professionals, noting the very different roles and responsibilities which should not be confused.
3. The tragic case of Dr Sridharan Suresh compelled the committee chair, along with the chair of council, to write to GMC regarding its support to vulnerable doctors and its communications to all doctors involved in fitness to practise processes. Importantly, this secured for the first time an acknowledgement by the GMC of the real and immediate risk to life for any doctor subject to investigation. The committee also pressed the GMC to conduct a comprehensive review of all its communications, which it sees as essential to ensure they are fit for purpose, with all doctors being met with empathy, fairness, and professionalism. It has called for improvements in the wider health and regulatory system so that responsible officers, medical directors, other clinical leaders, and external organisations such as the police, are able to better manage concerns about a doctor's fitness to practise.
4. Like all in the profession, the committee believe it is morally unacceptable for there to be unequal treatment of any sector of the medical profession in disciplinary or regulatory processes. Regarding the case of Mr Omer Karim, a doctor the GMC discriminated against on the grounds of race, the committee chair co-signed a letter to the GMC calling for a robust and comprehensive independent evaluation of its fitness to practise decision making procedures, and for immediate safeguards to be put in place to ensure fairness in handling any disciplinary referrals, including

additional external scrutiny. The committee will continue its work to secure this action from the GMC.

5. With the help of BMA lobbying, the GMC is due to lose its right to appeal medical practitioner tribunal decisions. However, the committee identified and challenged GMC plans to communicate with the Professional Standards Authority (PSA) following the loss of this right. The GMC intends to continue to review the outcome of cases and communicate its findings to the PSA as part of their considerations as to whether they wished to appeal. The committee was clear that the medical profession will be deeply critical of what it will see as an attempt to pursue tribunal appeals outside of the GMC's own legal framework, and that the GMC's pursuit of appeals by influencing PSA decision making is unnecessary and will only reinforce mistrust and contribute to the current culture of fear.
6. The committee also directly raised concerns about the GMC's recent engagement with registrants and the public on social media, following a high-profile incident where the GMC appeared to vindicate a vexatious complaint against a consultant doctor on Twitter that was highly likely to have been racially motivated. The committee have secured a commitment from the GMC that it will review its social media procedures. The committee will continue to monitor developments closely and engage with the GMC to assist with its review.
7. Following correspondence from the Occupational Medicine Committee on the management of complaints to the GMC, particularly those that do not proceed past triage to investigation and are therefore closed without the registrant being notified, the committee undertook an internal consultation exercise with branch of practice committees to determine a pan-BMA position. It has since combined this with knowledge of GMC processes to determine an approach to ensure the GMC seeks registrants' views on when they wish to be notified of complaints made against them and have flexibility to act on such feedback and amend its processes to suit.
8. The committee secured amendments to GMC policies and guidance that placed unjust burdens on doctors. For example, the GMC guidance on clinical attachments compels doctors who are suspended and undertaking clinical attachments to explain the reasons for their suspension to each patient they see. The committee raised this with the GMC who have confirmed that this should not apply for doctors whose suspension is due to health conditions. This will be made clear in upcoming versions of the guidance.
9. The committee challenged the GMC on the lack of payment options for GMC specialist fees. It noted that the current upfront payment requirement for specialist fees contrasts with the arrangements for the annual retention fee, due at the beginning of a doctor's registration year, where doctors are helpfully given the option to pay the fee in full, pay quarterly, or pay in ten monthly instalments. The committee called on the GMC to review its current fee structure and provide additional, flexible options for all the fees it sets. The GMC agreed to look in detail into the costs and timescale for making this change.
10. The committee has monitored changes to professional regulation that were implemented by the GMC in response to the COVID-19 pandemic. This includes the use of temporary emergency registration and the resumption of appraisal and revalidation, along with training and trainee progression throughout the pandemic. It has considered developments with the UK medical licensing assessment, engaged with the BMA's response to the accelerated graduation of medical students, and supported a BMA call to ensure diversity is better reflected in medical curricula. It has also kept abreast of developments with GMC-regulated credentials and contributed to the BMA's response to proposals for a medical degree apprenticeship.