Annex A

Summary and conclusions from an analysis of the nature and outcome of complaints received by the GMC, considered by the PPC and considered by the PCC in 1999, 2000 and 2001

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Introduction

This summary is drawn from a recent PSI analysis of GMC annual data available in computer records for the years 1999-2001, comparing them with the data for the years 1997 and 1998 presented in the last PSI report (Allen, 2000). It remains clear that analysis of the quantitative data alone cannot explain the differences between the outcomes for UK and overseas qualified doctors at the different stages of the GMC fitness to practise procedures which have been explored in detail in the two previous PSI reports (Allen, 2000; Allen et al, 1996).

Overview

The present analysis shows that the proportion of overseas qualifiers among complaints and enquiries received by the GMC about doctors whom it identifies has remained much the same over the past five years at just under 30 per cent (reflecting the proportion of overseas qualifiers in the medical population as a whole); that the proportion of overseas qualifiers sent to medical screeners has also remained at around 30 per cent over the same period; that the proportion of overseas qualifiers considered by the Preliminary Proceedings Committee (PPC) has remained at 39 per cent over the past three years, having decreased on the previous two years; while the proportion of overseas qualifiers appearing at the Professional Conduct Committee (PCC) has steadily increased over the period, from 48 per cent in 1997 to 58 per cent in 2001.

The screening stage

The picture has become more complicated by changes in the GMC procedures, whereby only 41 per cent of complaints and enquiries received by the GMC are now considered by screeners, compared with nearly 100 per cent in 1997. (This change followed PSI recommendations that screeners should not be sent inappropriate cases which were outside the GMC remit or could never raise an issue of serious professional misconduct or seriously deficient performance.) The present analysis did not consider any data on the remaining enquiries and complaints which are mainly closed after assessment by GMC staff according to strict criteria agreed with the screeners. Therefore no analysis has been made of the relative proportions of UK and overseas qualifiers in this population, or the reasons for the outcomes. The proportion of unidentified doctors among all complaints and enquiries received by the GMC is now 25 per cent. (No country of qualification is available for analysis in the case of doctors unidentified by the GMC.)

Medical screeners referred 25 per cent of the cases they considered to the PPC in 1999, 22 per cent in 2000 and 21 per cent in 2001. However, in all three years, higher proportions of overseas qualifiers than UK qualifiers were referred to the PPC by screeners, a ratio of 2:3, repeating the differential found in 1997 and 1998. The referral rates are as follows:

- 1999 – 22 per cent of UK: 34 per cent of overseas qualifiers
- 2000 – 19 per cent of UK: 30 per cent of overseas qualifiers
- 2001 – 18 per cent of UK: 27 per cent of overseas qualifiers

The last PSI report concluded that the most important factor affecting the higher rate of referral of overseas doctors by screeners to the PPC was the fact that a higher proportion of complaints about overseas qualifiers originated with public bodies (only about half of whom were connected with the NHS), and that such complaints were more likely to be referred by screeners to the PPC irrespective of country of origin of the doctor.

However, the most recent analysis has shown a more complicated pattern of referrals by screeners, leading to the conclusion that it is no longer possible to attribute the differential referral rates so clearly to this factor. We found that screeners now refer to the PPC a higher proportion of overseas qualifiers than UK qualifiers in the complaint categories of dishonesty/criminality and dysfunctional personal behaviour. It had been agreed in 1999 that all cases in such categories should be referred to the PPC as serious professional misconduct by definition unless the screener felt there were overwhelming reasons against such a decision. The GMC practice on this changed in 2001 so that some cases in these categories were left to the discretion of the screener but the GMC is now proposing to reverse this change.

The present analysis also shows that UK qualifiers are more likely to be referred to the health procedures and overseas qualifiers to the performance procedures by the screeners, particularly in cases referred by public bodies.

We found that there are notable differences between screeners, not only in the proportions of cases they refer to the PPC in general, but also in the relative proportions of UK and overseas qualifiers they refer. The pattern is more complicated than that found in the last report where the screeners were more likely to maintain their high or low referral rates to the PPC irrespective of country of qualification of the doctors. It is difficult to find the reasons for this on the basis of an analysis of the quantitative data alone.

The last PSI report established that cases were not allocated to screeners on a random basis and concluded that this could account for some of the differences between screeners. It recommended a completely random distribution of cases to screeners, and the GMC introduced a ‘cab-rank’ allocation of cases in 2000. It appears that screeners may not be applying common standards in their assessment of cases, as indicated by the fact that some refer more than 30 per cent of their cases to the PPC while others refer less than 20 per cent. In addition, although the average ratio of UK:overseas qualifiers referred to the PPC was roughly 2:3 over the period of analysis, some screeners had a ratio of almost 1:1 while others had a ratio of 1:3.

The Preliminary Proceedings Committee (PPC)

The proportion of *all* doctors considered by the PPC and then referred to the PCC increased markedly from 30 per cent in 1997 and 31 per cent in 1998 to 40 per cent in 1999 and 2000

and then dropped again to 34 per cent in 2001. The proportion of UK qualifiers sent to the PCC was much lower than the proportion of overseas qualifiers in all five years. The proportion of overseas qualifiers sent by the PPC to the PCC increased disproportionately between 1997 and 1999 – from 35 per cent to 52 per cent of overseas qualifiers considered. It remained at 50 per cent in 2000 and then dropped to 42 per cent in 2001. On the other hand, the proportion of UK qualifiers sent to the PCC increased from 27 per cent in 1997 to 33 per cent in 1999 and then dropped to 28 per cent of UK qualifiers considered in 2001. The ratio of UK:overseas qualifiers referred to the PCC by the PPC has remained at roughly 2:3 between 1999 and 2001, although it was much more even in 1997. It is unclear why the differential in referral rates has increased in the last three years.

The last PSI report concluded that it was difficult to discern the reasons for the disproportionate referral rates of overseas qualifiers by the PPC to the PCC on the basis of the quantitative data alone, although it noted certain anomalies such as the disproportionate referrals to the PCC of overseas qualifiers with convictions and those in the dishonesty/criminality and dysfunctional personal behaviour categories. These anomalies have remained. The last PSI report recommended that all convictions, other than drink driving, should automatically be referred straight to the PCC. It has now been agreed that convictions resulting in a custodial sentence should be referred straight to the PCC.

The Professional Conduct Committee (PCC)

This present analysis found continuing differences between the outcomes of cases concerning UK and overseas qualifiers at the PCC, but the factors determining these cannot be assessed without a detailed analysis of the reasons for the decisions made by the PCC.

Conclusions

This summary has been prepared only on the basis of an analysis of GMC quantitative data. The last PSI report examined further evidence we gathered from an analysis of screening decision forms and an observation study of the PPC, in order to cast light on the reasons for decision making at the screening and PPC stages of the GMC fitness to practise procedures. We found in that report that there were many areas where a lack of transparency and consistency led to the conclusion that it was difficult to demonstrate that all doctors in all cases were treated fairly, although we found no evidence that they were not.

It is possible that the complaints about overseas qualifiers are simply more serious and that their disproportionate referral rates and outcomes of hearings are fair and reasonable. However, until there are some objective measures which can demonstrate this, the GMC remains open to accusations of bias.

We conclude that the main problem in analysing the differences in outcomes between UK and overseas qualifiers at all stages of the GMC fitness to practise procedures remains the fact that there is no discernible common agreement on the criteria and threshold to be applied in reaching a judgment on the seriousness or gravity of cases. This has led to problems in ensuring consistency both within and between the different stages of the GMC procedures.

We observed in the last report that there was no common understanding of what does and does not constitute serious professional misconduct. We recommended that guidelines should be drawn up to ensure that a clear and agreed definition could be put into operation by all

GMC staff, screeners and members of committees, with agreement on the criteria, standards and threshold to be reached in making a judgment on whether a case represents or might represent a departure from the standards of conduct expected of doctors sufficiently serious to call into question a doctor's registration. The continuing differences between the outcomes of cases regarding UK and overseas qualified doctors in the fitness to practise procedures regarding conduct, health and performance suggest that such guidelines are a matter of priority, and that a close and continuing audit of decisions and outcomes at all stages of the fitness to practise procedures, analysed by country of qualification of the doctor, is essential.

It is to be hoped that the fundamental changes to be introduced shortly by the GMC in their fitness to practise procedures will build on the findings and recommendations of successive PSI reports.

References

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