General Medical Council

Medical Schools Council

Friday 18 May 2018
10.00 – 16.00

Woburn House, 20 Tavistock Square, London, WC1H 9HD

MSC-GMC
Student Fitness to Practise Conference

Attendees

Rosemary Belderboss	UCLan	Euan Lawson	Lancaster
Lois Brand	Oxford	John Paul Leach	Glasgow
Dan Burke	Barts	Georgina Lewis	Manchester
Helen Cameron	Aston	Brian Lunn	Newcastle
Fraser Chisholm	St Andrews	David Mabin	Exeter
William Coppola	UCL	Clare Mackenzie-Ross	Exeter
Alison Crook	UCL	Yash Mahida	Nottingham
Tim David	Manchester	Michelle Marshall	Sheffield
Catherine Davidson	Sheffield	Niamh Martin	Imperial
Alan Denison	Aberdeen	Mike Masding	Wessex Deanery
Caitlyn Dowson	Keele	Paul McGurgan	University of West Australia
Sarah Drewery	Leeds	Helena McNally	Oxford
Mike Eaton	Exeter	Louise Merritt	KCL
Anne Edwards	Oxford Deanery	Laura Mongan	Leicester
Suzanne Edwards	Swansea	Alice Morrison	Newcastle
Rachael Elliott	St George's	Karen Morrison	Southampton
Sarah Ellson	Fieldfisher	Jane Pallant	Barts
Angela Fairclough	Sheffield	Julie Pearcy	Lancaster
John Firth	Cambridge	Hannah Quinn	Bristol
Sally Foster	Buckingham	David Russell	Dundee
Rosalind Fuller	KCL	Janette Shiel	Imperial
Jayne Green	Cambridge	Claire Skelly	OIA
Jason Hall	Manchester	Anne Stephenson	KCL
Julian Hamilton-Shield	Bristol	Ruth Stewart	Glasgow
Ali Hashtroudi	HEOPS	Claire Stocker	Buckingham
Andrea Hilton	Hull York	Helen Sweetland	Cardiff
Kenwyn James	Southampton	Ann Thornton	Otago Medical School, NZ
Robert Jarvis	Dundee	Sarah Venning	Nottingham
Viktoria Joynes	Liverpool	Claire Vogan	Swansea
Neil Kennedy	Belfast	Shonagh Walker	Aberdeen
Hisham Khalil	Plymouth	Aideen Walsh	Keele
John Kinnear	Anglia Ruskin	Kate Whittington	Bristol
Peter Knap	Hull York		

Tanita Cross	GMC	Emma Horan	MSC
Blake Dobson	GMC	Ioanna Maraki	GMC
Martin Hart	GMC	Clare Owen	MSC

Professor David Mabin introduced himself and Dr Anne Stephenson as co-Chairs for the meeting and welcomed attendees. He reminded delegates of themes that would be explored during the meeting: honesty, health, and the link between undergraduate and FY1. Delegates were invited to attend a short filming session over lunch to discuss the role of student fitness to practise which will be added to the GMC's website.

Honesty – legal and practice considerations

Recent developments in case law – Sarah Ellson, Fieldfisher

Sarah Ellson outlined three recent cases that had led to a change in case law regarding dishonesty.

1. Ivey vs Genting Casinos: Mr Ivey, a gambler, had been talking to a card dealer in a Casino about his superstitions about cards going into a deck in a particular way. He left the casino and later returned. The deck had not been changed and he went on to win £7million. It was deemed that the Ghosh test was too subjective in determining if Ivey knew that others would think he was being dishonest and was not valid. Case law has been updated and whilst it still seeks to understand a person's state of mind, consideration must be taken to determine if the actions are dishonest by applying the objective standards of ordinary people.
2. GMC vs Krishnan: Dr Krishnan was signed off work on long-term sick leave for stress and was found to be working as a locum for another employer during this time. He argued that the work he was undertaking was not stressful, so the terms of his sick leave did not apply. In this case, dishonesty was found to be not proved applying the Ghosh test. The GMC appealed this case applying Ivey and Genting as most other people would consider his actions dishonest.
3. GMC v Raychaudhuri (it was noted that this case was subject to an appeal hearing in July 2018): Raychaudhuri had completed entries in patient records using GP notes before consulting with the patients. His actions were found not to be dishonest as he had believed it to be time-saving to complete some parts of the records before seeing the patients. The GMC are appealing using Ivey.

Some hypothetical examples were presented of scenarios that schools may come across with their students and the considerations they would need to take into account when determining the outcome (available in the slides).

In light of this change in case law, Sarah Ellson recommended that guidance and training materials for Fitness to Practise panels may need to be updated so that whilst panels still explore the credibility of a student's belief that they had not acted dishonestly, consideration about whether the conduct is dishonest by the standards of ordinary people must be taken as the final step in determining the outcome.

Q&A

Q: In most cases students admit to the dishonest actions. What if the panel determine actions were dishonest but the student continues to argue that they were not? Should this lack of insight impact on the outcome?
A: There will always be a scale of flawed/innocently flawed/warped views from students on their behaviour. If a student repeatedly fails to recognise the dishonesty found by the panel, it may affect how

they behave and reflect in future. By failing to admit to behaviours found to be dishonest it may cause problems in future.

Q: If a student has Asperger's, should this come into consideration when applying their behaviour by what's expected of others?
A: You would still apply the reasonable and credible test. Asperger's may mean that they behave in a certain way and you may need help on the FtP panel from an expert who can advise on behaviours associated with Asperger's. In that context you can judge their behaviour.

Q: Student FtP guidance talks about lack of probity rather than using the term 'dishonesty'. When drafting allegations is this term an adequate substitute?
A: No. lack of probity is more nebulous subject. Phrase of "lack of integrity" also used. They are not the same thing. If you want to find a student dishonest you should use the term dishonest.

Q: How do you handle situations where a student lies at the FtP panel on topics not included in the original allegations?
A: It happens often. If it happens in a hearing you have to be careful with language. A decision on the alleged behaviour cannot be made based on accounts given by the student at the hearing, but you can note that at the hearing they failed to provide consistent and credible answers, and that you disbelieved evidence. There are ways to show that more adverse view on what happens next is based on evidence as well as what is heard from the student.

Real life example of dealing with dishonestly – Prof John Paul Leach, Glasgow

Professor John Paul Leach from Glasgow medical school shared a recent experience the school had with dishonesty amongst its students. In March 2017, the school had discovered that some of its students had been sharing details about its clinical Finals via a Whatsapp group. He explained that the school ran OSCEs across five days and three venues, and students sit cycles in random order on different days. Although there is some modification, the content is largely consistent, and there was no quarantining of students.
Following the discovery of collusion, the school took the decision that all students would need to retake their clinical exams and the previous sitting's results would be void. Those found to be participants in the Whatsapp group were interviewed by the university senate and the GMC were notified. There were mixed outcomes for those individuals based on the seriousness of their involvement, including no sanction, their next attempt to be classed as a 2nd sit and their name on record with the GMC, and FtP panel referrals for the most serious, pre-planned cases.
As a result of the incident, Glasgow has revised the format of its clinical Finals exam. From 2018 all students will take their exam on the same day, with four sets of four stations run across the morning and afternoon, with quarantining in place for the whole day. The longest students are quarantined is two hours, once or twice in a week. Although Glasgow has changed how it runs its Finals OSCEs, it was noted that a study by Ghouri et al looking at OSCE data over six years found that the date and time of completing stations has no effect on pass rates.

Q&A

Q: When you made enquiries, did it bring to light any similar incidents from previous years?

A: We think that this was an incident confined to that group of students. Talking to previous students, whilst they admitted talking in general about OSCEs, they said no details about exams were routinely shared.

Q: Were similar issues in other years highlighted as a result?
A: The lower years are aware of what happened and lines have been drawn. In cases of academic fraud, it's often where there are open book exams, then the final exam is closed book with no discussion permitted. Sharing details and then not allowing to share is an issue. Glasgow previously had a formative OSCE in second year that students would discuss; this has now been changed to summative to reflect Finals, so all exams are treated the same way throughout the course.

Q: Were you concerned about the mental health of the students involved and what did you do to support them?
A: All students involved met with head of student welfare. Some required more support but most did not need it.

Q: Did any of the students make the argument that this situation was not dishonest?
A: Very early on a couple said they knew people in other years who had shared exam details before. The school's view is that patient safety is paramount. Students thinking it was habitual student behaviour was deemed unacceptable by the school. Some students had argued that it was inevitable if the school did not quarantine but documentation had been circulated ahead of the exam to make it clear that sharing details of exam content is unacceptable.

Q: Do you think we will be able to run a standardised OSCE for the MLA?
A: It will be very difficult to run this on different days but we will need to find a way to make it work.

Health and disability

<u>Student account of their experience of Fitness to Practise and mental health</u>

A student who had previously been referred to a Fitness to Panel panel shared his experience with attendees. He explained that before starting university he'd taken two gap years, one of which was used to retake his A Levels as he had not achieved the necessary grades to enter medical school. He'd found the jump from school to university a challenge, from spoon-fed teaching to being more challenged academically. He threw himself into the social side of university and as a result had to repeat the first year. He told of the pressure he put on himself to improve academically and as a result became a recluse, failing to attend lectures as he felt he could learn new information whilst studying independently. After a week of solid studying, he found himself too tired to do any more and on his days off he would drink and smoke weed. Despite passing the year, Occupational Health referred him to a Fitness to Practise panel. He explained that initially he was angry at the decision and didn't think his actions had affected patient safety. With his course delayed for another year he found himself revisiting bad social habits.

Upon reflecting on his year out, he said the time off forced him to look at his behaviour. He described the positives that undergoing FtP proceedings had had on him including changing his attitude towards studying and making him more aware as a student. He is now back studying and on track to graduate as planned. Some feedback he had for the school about the FtP proceedings was that communication

could be improved. He explained that he had felt that the process had been meeting-driven and that he didn't feel as though his input was valued.

Q&A

Q: What advice would you give to schools with students in the same position?
A: It would be helpful to look at the background of the student for context. Schools should also appoint older student mentors or tutors to inform them of why certain behaviours impact on their career and advise on how to address these early on.

Q: If you had had to decide on the remediation, would you have suggested a year out of studying?
A: I don't know. I didn't want to have to take a year out at the time but in hindsight it was helpful. It helped me to reflect on my behaviours and return more focused. If I had been allowed to continue studies there is a chance I may have not taken it seriously.

Q: What can medical schools do to help students with study pressures?
A: In my first year we had talks from older students tutors to reassure us, but how you are as a learner determines how you study. At university you are told what topics to learn and you learn it in your own way. If you are not used to independent study you can panic, which is what happened to me. Talking to other students about how they're studying can end up driving you to do more – medicine is a competitive subject. From the medical school side, what is helpful is when we fail an exam we have a remediation process where two pastoral tutors speak to students about how they study, how much they're sleeping, worries in personal lives, etc. Students may be offered more support. My advice to schools is to talk to students and give them time.

The Chair thanked the student for sharing his experience. He highlighted that taking a year out of studying is often very helpful, but that students are often reluctant to take it. He noted the importance of making students aware that a year out will have no negative impact on their career.

Update on GMC Health & Disability review – Ioanna Maraki, GMC

Ioanna Maraki outlined the GMC's health and disability review and the work that had been done to update the Gateways to the Professions guide. It was noted that it is currently in draft form so what was being presented is subject to change.

It was highlighted that one in five people in the UK is disabled, and that widening participation work is looking to support students with disabilities. Making adjustments to support those with disabilities so that they can meet the outcomes of Tomorrow's Doctors will ensure there is not a shortage in the workforce.

Ioanna talked about the guides for schools and students that have been created jointly by the GMC and MSC and highlighted key points from them on health and student fitness to practise. Ioanna outlined the student perspective from the GMC's consultation on the health and disability review and pointed out that students said they were hesitant to share information if they didn't know if they had a health condition or disability (if they have symptoms but have not been diagnosed), they did not know what support is available, and were worried about SFTP implications. There were also roundtables where students fed back that they felt medical schools use the guise of competency to disguise discrimination, students had little knowledge about what would happen after graduation, they worried that fitness to practise would

automatically be questioned if they seek support for a health condition, and that there was a general assumption that medical students cannot suffer from ill health.

The new Welcomed and Valued guide was introduced and some key messages were outlined, including the GMC's considerations as the professional regulator, and how medical schools can apply their duties.

A table discussion took place asking delegates to consider the following:

1. What qualities make a good doctor? Is having a disability compatible with these qualities – why or why not?
2. Discuss recent requests for support at your medical schools in light of the factors for consideration of what is reasonable from the EHRC
3. The EHRC says that a risk to the health & safety of anyone is a factor that is considered for deciding whether something is reasonable, but at the same time that the decision must be based on a proper, documented assessment of risk. The GMC/MSC professionalism guidance also says you can consider SFTP for a student with a health condition where there are significant concerns about patient safety. How can you follow these two pieces of guidance to properly assess the risks to patient safety and document these concerns if you want to proceed with SFTP processes?
4. The GMC & MSC guidance makes it clear that medical schools can only graduate students who are deemed fit to practise. Discuss recent cases with of students with disabilities & long-term health conditions who have been through SFTP processes, and your considerations for allowing them to graduate or not.
5. How do you respond to the findings from the research and roundtable discussions with disabled medical students:
    - Sense that [disabled] students are 'in trouble' and have their fitness to practise automatically questioned if they request support.
    - Impression that medical schools use the 'guise' of being competent to disguise discrimination [against disabled students]

Tables were invited to feedback one point from the discussion:

- There needs to be consistency. It can be difficult to apply the flowchart from the slides as students start the course at different stages.
- Sometimes when a student receives an adjustment, other students complain it is not fair (e.g. staying in a base hospital and not having to go out to communities for clinical placements). This can be difficult to manage.
- There is a very short timeframe between students accepting a place and convening panels to consider adjustments before they begin the course. Deferred entry may be the way forward.
- Declaring a disability on the UCAS form is voluntary – should this change?
- The disability support team often provides a long list of recommendations for adjustments. When meeting with students they often feedback that they do not require the adjustments and often come up with other, better suggestions.
- Case histories where reasonable adjustments were applied and worked, and also where adjustments were requested and denied, would be useful.
- Students with mental health conditions – what reasonable adjustments are available to them as graduates? Universities often make more reasonable adjustments than the student would get in clinical practice.
- Enabling reasonable adjustments to reach outcomes for graduates is not the same as being able to work in the NHS. It can be a challenge to highlight this to students.

'Doctors in difficulty' – FtP and the Foundation Programme

The link between medical students and F1s, and cases referred to the GMC – Blake Dobson, GMC

Blake Dobson presented on the role of the GMC's Employer Liaison Advisors (ELA). He explained that the role was created to address the perception of the GMC's lack of understanding as a regulator, and employer's lack of understanding of the regulator's role. ELAs provide guidance and advice regarding individual doctors with issues being raised about them, and revalidation issues.
The creation of the Employer Liaison Service was to assist the GMC in its aim in driving down the activity it expends on Fitness to Practise. A lot of resources are spent investigating cases where the GMC do not take action on a doctor's registration. As a result of ELAs, the number of GMC investigations has dropped over the last five years, with many closed immediately or referred back to the employer.

Blake outlined the range of support for doctors facing Fitness to Practise allegations including medical defence organisations, the BMA's 'Doctors for Doctors' service (where any doctor subject to a GMC investigation can seek support, not just BMA members), Doctors Support Network, Sick Doctors Trust, the GMC's Your Health Matters guidance, Practitioner Health Programme, and MPTS phone service. He reiterated that the GMC is not there to punish doctors for making mistakes, but there to protect the public and maintain the public's confidence in the profession. He pointed out that less than half of complaints turn into GMC FtP investigations.

The audience were reminded of some key professionalism guidelines from Achieving Good Medical Practice and were presented with some scenarios to discuss whether they thought the issues were considered serious, and if they would expect them to be raised with the GMC.

Examples of F1 Fitness to Practise issues and what medical schools could do differently – Dr Mike Masding (Wessex deanery) & Dr Anne Edwards (Oxford deanery).

Foundation school directors, Dr Mike Masding and Dr Anne Edwards, outlined the developments that have helped to improve the transition from medical student to FY1, including educational supervision, shadowing periods, student assistantships and the Prescribing Safety Assessment. They noted that in general, overseas F1s are overrepresented in doctors who struggle and that this was generally due to not understanding acronyms. It was explained that each deanery has a Professional Support Unit (PSU) for its trainees and that it works well when deaneries have a strong link with their medical schools to provide support for medical students transitioning into FY1. Mike Masding noted that Wessex has one medical school under its jurisdiction which works well, and recognised that it would be more difficult for deaneries with more medical schools.

Provided three examples where trainees had struggled in the F1 year and examples of good practice in these cases included:

- Early referral to Occupational Health. It was noted that university OH services manage students and academics, but recommendations may be different for F1s.
- Agreement now for acute Trust Occupational Health assessments to be done whilst they are still a medical student. This gives Trusts more time to make adjustments for their F1 placements.

Recommendations Mike Masding and Anne Edwards had for students/trainees with difficulties included:

- Better liaison between the deanery and medical school about problem cases
- Engaging FSDs with FtP panels
- Early meetings between medical schools and FSDs to help schools plan for students with known challenges
- Review of the TOI process – to capture those not part of discussions but might still need support
- Consistency across the country
- Early intervention for students who may be more suited to other careers
- To consider what the right balance is between fairness for those with disabilities and pragmatics of a career in medicine.

As part of the FSDs' involvement with the GMC on its Welcome and Valued work, it has been recommended that a Special Circumstances W&V meeting takes place in autumn and that medical schools identify students that need support and notify the local deanery as early in the course as possible, at least by the penultimate year.

Q: How can we increase the uptake of early PSU referrals?
A: Early insight is so useful. We can only refer students to PSU with their consent. It's a red flag if the referral is turned down as in these cases, there are often other concerns about the student.

Q: Some students start training at a deanery other than the one local to their medical school. How do we improve their transition?
A: We should encourage people to speak. FSDs should communicate with each other where appropriate. The primary focus should be on patient safety. There is still an issue with overseas graduates as their TOI forms often do not disclose much information. We may need to ensure we meet the new GDPR requirements for data sharing.

The Chairs thanked the audience for attending the meeting and invited them to leave their thoughts on what topics to address next year on the feedback forms.