

COVID-19: assessing the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic

Purpose

- 1** The purpose of this document is to support decision makers in determining how to assess the overall risk to public protection (including patient safety, public confidence and upholding professional standards) posed by a doctor in relation to allegations of impaired fitness to practise in a clinical setting during the Covid-19 pandemic, considering the specific circumstances which arose.
- 2** This guidance provides support to decision makers on how to take into account the circumstances which have arisen as a result of the Covid-19 pandemic and how they impacted on the systems in which a doctor was working and on how they delivered care. Guidance on considering other matters such as a doctor's personal or domestic situation, testimonials about their general standards of practice or remediation of an identified failing are provided in other guidance for our decision makers.
- 3** Decision makers should consider this guidance alongside:
 - [Good Medical Practice](#)
 - [Guidance - GMC Thresholds](#)
 - [CE Decision Guidance - Making decisions on cases at the end of the investigation stage](#)
 - Guidance for decision makers on when to take a doctor's fitness to practise history into account
 - Guidance for decision makers on Provisional enquiries
 - Part A – Overarching principles of Provisional Enquiries
 - Part B – Assessing suitability for a Provisional Enquiry

- Part C – Allocation to a Provisional Enquiry stream
- Part D – Carrying out a Provisional Enquiry
- Part E – Deciding the outcome of a Provisional Enquiry

Background

- 4 The Covid-19 pandemic has placed unprecedented demands on our social structures and healthcare systems. In turn, it has created significant and unfamiliar challenges for healthcare staff, including doctors, in delivering safe and effective healthcare.
- 5 All our ethical guidance continues to apply as far as is practical in the circumstances. The primary requirement for all doctors is to react responsibly and reasonably to the situations that they face based on the circumstances at the time. The [Ethical Hub](#) sets out how a doctor might act professionally in line [Good Medical Practice](#). In addition, our [Frequently Asked Questions About Covid-19](#) briefing provides useful information to support doctors.
- 6 The pandemic has not affected all communities equally. There are disparities in the risk and outcome of Covid-19 for those belonging to some ethnic groups¹ and it has exacerbated and amplified the persistent and unjust inequalities in health across society². There has been a disproportionate burden of disease and mortality carried by clinicians, including doctors, from black and other minority ethnic (BME) communities.
- 7 Inequality and discrimination means that BME doctors' experience of medicine can be very different to that of their white colleagues. We know that BME doctors are more likely than white doctors to be referred to the GMC by employers. GMC research has shown that this is linked to differences in workplace perception and treatment involving a lack of effective induction, feedback and support; working patterns that leave some doctors isolated and unable to access as many learning opportunities as others, organisational cultures that treat some doctors as 'outsiders' and focus on blame rather than learning when things go wrong; and some leadership teams being remote and inaccessible³.

Approach

- 8 As with any case, when we consider an allegation raised about a doctor's fitness to practise during the pandemic, we consider the circumstances that existed at the time. This guidance supports decision makers in considering the specific Covid-19 related

¹ [PHE Review](#)

² [UCL Institute of Health Equity](#)

³ [Fair to Refer?](#) report commissioned by the GMC and conducted by Dr Doyin Atewologun and Roger Kline

circumstances that have arisen as a result of the pandemic, their impact on the system within which the doctor was working and on the doctor's practice and/or conduct.

- 9** Whether the doctor poses a risk to the public and the extent of that risk will be determined on a case by case basis. We will weigh up the various factors set out in this guidance as they relate to each specific case to determine whether the doctor poses a risk, keeping in mind our overarching objective to protect the public. Protection of the public includes:

- protecting and promoting the health, safety and wellbeing of the public
- promoting and maintaining public confidence in the medical profession
- promoting and maintaining proper professional standards and conduct for the members of the profession

- 10** Decision makers should take into account the specific issues relating to the circumstances which have arisen as a result of the Covid-19 pandemic that include, but are not limited to:

- the availability and distribution of resources to provide healthcare and the change in healthcare provision due to social distancing guidance
- the uncertainty and rapidly evolving evidence-base about a novel disease and effective care and treatment
- the disproportionate impact of disease and mortality rates for individuals from black and minority ethnic groups (BME)
- access and availability of personal protective equipment (PPE)
- staff shortages due to Covid-19 infection or self-isolation requirements
- ways of working outside of normal routine and practice and requirements to work in unfamiliar roles, teams and/or environments at short notice
- changing and sometimes conflicting guidance and protocols, often produced and communicated quickly
- wearing PPE for extended periods of time can create discomfort and impede communication with patients and colleagues
- the effectiveness of existing clinical governance processes creating unexpected challenges for leaders and managers.

- 11** We know that doctors faced sustained and extreme periods of fatigue, and in some cases significant distress and emotional trauma during the pandemic. These factors are important consideration of the doctor's personal circumstances, which is covered in other guidance for decision makers.
- 12** Considering the difficulties and pressures doctors were facing at the time of an incident during the Covid-19 pandemic, we will consider how they sought to:
- provide the best and safest care they can in line with the best evidence available at the time
 - communicate effectively and work cooperatively with colleagues to keep people safe
 - challenge and report poor practice or issues which negatively impact on their practice, escalating their concerns rapidly
 - demonstrate that they have tried and exhausted other reasonable means to address any issues and concerns; and/or
 - keep records of the decisions they make and the actions they take.
- 13** Having considered the circumstances which have arisen as a result of the Covid-19 pandemic when considering allegations about a doctor in a clinical setting, this may result in the allegations:
- being unlikely to raise a question of impaired fitness to practise
 - being unlikely to raise a question of impaired fitness to practise but involving possible failings where there is an opportunity for reflection and improvement
 - being unlikely to raise a question of impaired fitness to practise because, while on the face of it serious, information gathered indicated that the doctor's actions and/or conduct were reasonable in the circumstances of the pandemic; or
 - being likely to raise a question of impaired fitness to practise having taken the circumstances of the pandemic into account.
- 14** The examples given in the guidance are intended for illustrative purposes only, and decision makers must assess each case on its own merits, ensuring they take the minimum action necessary to protect the public.

Allegations in a clinical setting during the pandemic that are unlikely to raise a question of impaired fitness to practise

- 15** We only need to take action on a doctor's registration where an allegation raises a question about a doctor's fitness to practise.
- 16** The following factors may indicate that an allegation about a doctor in a clinical setting during the pandemic does not raise a question about their fitness to practise. This is an indicative and not an exhaustive list:
- the doctor's actions or decisions are a reasonable response to the pandemic where guidance with which they might usually be expected to comply was lacking, inconsistent or unclear, or the guidance did not anticipate the unusual circumstances that arose or was conveyed by means, such as emails and social media, with which they were less familiar
 - the doctor was unable to see a patient in the usual way, for example, undertaking remote consultations using video rather than face to face
 - care for non Covid-19 related treatment during the pandemic was delayed. For example, as a result of having to conduct remote consultations the doctor took reasonable steps, but the care was delayed because access to treatment or services were delayed or were not available during periods of the pandemic, such as diagnostic services
 - while the treatment of the patient was appropriate, the doctor also advocated for alternative medicine in treating Covid-19 as part of general health and wellbeing advice
 - the concern relates solely to the specific choice of treatment by a doctor. We do not adjudicate on the rights or wrongs of developing or cutting-edge therapies; it is not within our remit
 - the concern relates solely to the fact that a doctor raised concerns about the availability or suitability of PPE and the way in which they did so did not involve any misconduct
 - the doctor's use of PPE was outside the approach that is usually expected but this was an agreed response to the circumstances at the time. For example where diminishing stocks resulted in doctors reusing or reducing the amount of PPE they wore, and they raised concerns about patient safety with suitably qualified colleagues regarding the availability or suitability of PPE.

Allegations in a clinical setting during the pandemic that are unlikely to raise a question of impaired fitness to practise but there are matters that a doctor should reflect on

- 17** We may receive allegations which, in and of themselves, do not raise a question about the doctor's fitness to practise, but there are matters that the doctor should reflect on as part of their regular reflective practice and appraisals.
- 18** Examples of these types of allegations arising in a clinical setting during the Covid-19 pandemic may include, but are not limited to, where it is alleged that a doctor:
- did not communicate well with patients or colleagues when it was possible to do so or was impolite or rude
 - kept records but their quality was not of the standard expected. For example, where they were illegible or incomplete and while the circumstances of the pandemic may have had an impact and full records were not possible, even in those circumstances, better quality records could have been made
 - felt unable to continue to work safely without PPE but didn't handle their concerns in a professional manner. For example, not consulting a suitably qualified individual
 - offered non-essential treatments or operated non-essential services where there was direction to focus on essential care, but with no detriment to patient care
 - misdiagnosed a patient who had Covid-19 but under the circumstances there was a reasonable enough explanation for the approach taken and judgement made, such as the timing of the diagnosis in relation to the stage of the pandemic.

Allegations unlikely to raise a question of impaired fitness to practise because, even though on the face it serious, information gathered indicated that the doctor's actions and/or conduct were reasonable in the circumstances of the pandemic

- 19** We may have an allegation that appears to raise a question about a doctor's fitness to practise but we receive further information or clarification that suggests that the circumstances which have arisen as a result of the Covid-19 pandemic indicate the allegation does not raise questions about a doctor's fitness to practise.
- 20** Examples may include, but are not limited to, where:

- a doctor's action appears to have put patients at risk during the pandemic, but we ascertain that at the time clear guidelines about those aspects of treatment were unavailable, not easily accessible, or there were conflicting guidelines
- a doctor's actions have led to harm or risk of harm to a patient, but the doctor was required to work outside their usual area of practice with limited or no support and guidance to do so safely
- a doctor failed to escalate an issue or failed to respond to an escalating situation during the pandemic but this was reasonable given what could have been expected or what was possible in the circumstances at that time
- a doctor made a decision to deny access to treatment but this was a reasonable decision in the circumstances of the pandemic at that time
- a doctor failed to take reasonable steps in planning for a change in a patient's capacity to make decisions about their care, but the doctor's actions were appropriate in the circumstances they faced
- a doctor did not treat a patient due to a lack of PPE, but the doctor was at a higher risk of infection and had raised concerns with their employer or tried to make alternative arrangements for the patient where treatment services were available
- a doctor did not wear available PPE when treating a patient when the dangers of this were known, but the doctor's actions were reasonable in the circumstances. For example, where the treatment was urgent and necessary in an emergency, no one else was available to treat the patient, they did not know that PPE was available and would have provided adequate protection, or they were not able to access it.

Allegations in a clinical setting during the pandemic that are likely to raise a question of impaired fitness to practise after having taken the circumstances of the pandemic into account

- 21** Despite the circumstances of the Covid-19 pandemic, a doctor's actions may have been reckless or so serious that the circumstances of the pandemic is unlikely to reduce the risk they pose to public protection.
- 22** This could be because the nature of the allegation is such that the circumstances which have arisen as a result of the pandemic are unlikely to reduce the risk posed by the doctor (such as serious misconduct allegations); or where the allegations relate to serious failings over a sustained period, or with multiple patients, not limited to care during the Covid-19 pandemic.

23 Examples of these types of allegation could include, but are not limited to where a doctor:

- acted in a reckless manner which presented a serious risk to patient safety during the pandemic
- knew or suspected that they had Covid-19 that they could pass on to a patient and continued to work without consulting a suitably qualified colleague
- refused to wear PPE and treated a patient when the dangers of this were known, where they knew that PPE was available and accessible, and no reasonable justification has been identified
- based decisions on access to or prioritisation of treatment purely on the patient's protected characteristics where there was no reasonable justification for their decision
- infringed the patient's autonomy by failing to obtain their consent to their treatment or care, or that of their legal proxy, where it was possible to do so
- failed to take reasonable steps in planning for a change in a patient's capacity to make decisions about their care where there was no reasonable justification for their decision.