Exploring remediation in Fitness to Practise at the General Dental Council

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Executive summary

Background

Remediation is a crucial component of healthcare regulation, aiming to balance public protection with recognition that professionals may face personal or professional challenges affecting their ability to practise safely and effectively, in line with established professional standards.

The need for remediation can arise from various issues, such as clinical errors, communication problems, poor record-keeping, ethical lapses, or difficulties in maintaining up-to-date knowledge and skills. Ideally, rather than relying on punitive measures, remediation should be a formative process including education, practitioner reflection, support, and professional development to help practitioners overcome their challenges. This process typically involves a thorough assessment of the individual's performance, identification of specific areas needing improvement, and the development of a tailored remediation plan. This plan may include additional training, mentoring, supervision, and ongoing evaluation to monitor progress, including by peer review.

The ultimate goal is to support healthcare practitioners in reaching and maintaining the required standards, ensuring the delivery of patient care which is not only safe but also effective. Importantly, healthcare regulation must also satisfy the need to maintain public confidence in the profession, as remediation may sometimes be incapable of addressing the broader issue of public confidence even if it satisfies a regulator's test of current and likely future impairment.

At the heart of this research project was the General Dental Council's (GDC) interest in considering remediation as a potential mechanism for closing Fitness to Practise (FtP) cases at an early stage in the process. Currently, many referrals result in registrants progressing to a full fitness to practise investigation, with the time delays involved and the nature of the hearings themselves proving costly for registrants' mental health and wellbeing. For appropriate cases, early remediation may provide an opportunity for registrants to assure the regulator that any perceived deficiencies in their practice have been adequately addressed, such that there is no requirement for them to progress to the later stages of the FtP process.

Aims

The primary aim of this research was to provide evidence to inform the GDC's approach to remediation, including the potential for it to be integrated into case decision-making at an earlier stage in the process, specifically before reaching the Case Examiner stage. This involved exploring how regulators in both health and selected non-health sectors operate, manage, and evaluate their approaches to remediation, comparing these practices to the GDC's current approach, and identifying potential areas for learning and improvement. The research also aimed to identify, from the perspective of GDC staff, which aspects of the current remediation process are working well, what areas require improvement, and what the GDC's journey to a better system might entail.

Methods

Ethical approval for this study was granted by Newcastle University (reference: 38982/2023). The research employed a combination of documentary analysis and qualitative interviews. The documentary analysis aimed to understand and inform the GDC's current approach to remediation by reviewing the practices of comparable regulators and identifying areas of best practice and potential improvements in monitoring and evaluation. Documents were sourced from relevant websites,

targeted emails to key stakeholders, and a limited rapid literature search, with consideration given to synonyms such as remedial conditions, undertakings, and revalidation.

The qualitative data collection involved interviews with relevant GDC staff, including the regulation and fitness to practise (FtP) team members such as directorate leads, case examiners, policy workers, and the legal team. A focus group discussion with twelve GDC colleagues was held to sense-check interim findings from the internal stakeholder interviews and serve as a checkpoint before approaching external stakeholders. Further interviews were conducted with a range of stakeholders, including healthcare and non-healthcare regulators, defence unions, and legal representatives familiar with the GDC's and other regulators' FtP processes. The qualitative data analysis took the form of reflexive thematic analysis, with interviews and focus groups being recorded and transcribed verbatim. Themes were developed deductively from the documentary analysis and inductively from the qualitative data, with purposive sampling and snowballing used to ensure informed perspectives were included.

Findings

Remediation is widely regarded as the right direction of travel for improving fitness to practise (FtP) processes. There is a relatively unified vision within the GDC to consider remediation at the earliest possible opportunity, ideally at the Assessment stage. Effective remediation should be tailored and fit for purpose, allowing practitioners to address specific deficiencies through targeted interventions. The GDC's approach aligns with other regulators who also emphasise the importance of remediation in their FtP processes, seeing it as beneficial for all parties involved.

The legal framework surrounding remediation emphasises the need to balance public safety with professional support. Case law indicates that remediation should be considered as part of the ongoing FtP process, with the aim of ensuring and maintaining patient safety. This involves recognising and addressing deficiencies early to prevent more serious issues from developing. The process must also maintain public confidence, ensuring that remediation efforts are seen as credible and effective.

There are mixed views on the acceptability of remediation among different stakeholders. While patients and patient advocacy groups may favour punitive measures, there is an understanding that effective remediation can ensure future safety and quality of care. Indemnifiers and registrants generally view remediation positively, seeing it as a way to resolve issues without resorting to more severe sanctions. However, there is some apprehension about the level of support from the Professional Standards Authority (PSA) and patient bodies, which may view remediation as a lenient approach.

Reflective practice and tailored opportunities for improvement are crucial for ensuring that remediation efforts are impactful. There is a need for clear guidelines and transparent processes to ensure that remediation is considered consistently and effectively across different cases. The GDC must foster a supportive environment that encourages early engagement in remediation activities. This includes taking a ‘risk-positive' approach, in which there is greater tolerance of the relatively low-level risk presented by certain registrants in particular contexts.

Several barriers hinder the effective implementation of remediation. An adversarial culture within the FtP process, lack of trust in the GDC, and challenges faced by registrants in engaging with remediation efforts are significant obstacles. Building trust and fostering a supportive regulatory

environment will be essential for successful process reform, requiring a cultural shift within the GDC and a commitment to supporting practitioners in their remediation efforts.

This research highlights the need for cultural, policy and potentially legislative changes to enhance and develop the GDC's remediation practices. This includes promoting a shift from punitive to supportive measures, ensuring that remediation efforts are meaningful and effective. Clear guidelines, transparent processes, and a focus on professional development are crucial for achieving this aim. The GDC must also engage with stakeholders to build trust and support for its remediation initiatives, ensuring that they are seen as credible and effective in maintaining public confidence.

Conclusion

The study provides a comprehensive overview of the current state of the GDC's remediation approach and offers actionable recommendations for enhancing these practices. The findings highlight the need for cultural shifts and legislative support to implement meaningful remediation processes. The research underscores the importance of facilitating early and effective remediation within the GDC's regulatory framework. By emphasising support over punitive measures and fostering a trust-based relationship with registrants, the GDC has the opportunity improve professional standards and public confidence in the dental profession while supporting the mental health and wellbeing of registrants through the early closure of appropriate cases.

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1 Background

> "How we approach remediation, both of learners and of practicing health professionals, is a critical reflection of the professional values that we aspire to, that we espouse, and that we experience. Although a minority of learners, teachers, and practitioners will have firsthand experience of remediation during their careers, everyone is (or should be) aware of it, and everyone needs to be able to trust that it is effective, proportionate, and just." (Ellaway, 2023)

GDC Fitness to Practise (FtP) investigations can be time-consuming and complex, with serious consequences for the health and wellbeing of registrants (GDC, 2023). Currently, 'nearly all' cases concerning registrants' clinical practice progress to a full FtP investigation (GDC, *ibid*.) such that registrants whose cases are at the least serious end of the risk spectrum are caught up in protracted FtP processes. Indeed, it is the GDC's view that for all referrals relating to the 'health, practice or behaviour of a dental professional…too many of the issues raised with [the GDC] have fallen unnecessarily into [the FtP] category,' (GDC, *ibid*.)

Consequently, the GDC is keen to pursue proportionate approaches to regulation – sometimes known as 'right touch' regulation (PSA, n.d.) – including through timely engagement with registrants to resolve cases at an early stage in the FtP process. One such initiative – the initial inquiries pilot - has involved asking registrants to share information, primarily patient records, with the aim of closing low-risk cases early, and initial signs are that this project has been successful (GDC, 2024). Another area of interest, into which this research will feed, is the consideration of registrants' efforts to remediate and whether and how they might be factored into the initial stages of the FtP process with a view to closing appropriate cases at an early stage.

Remediation is variously defined and understood. Remediation in fitness to practise refers to the process of assisting healthcare professionals who may be struggling with their performance or conduct to improve and meet the required standards (Dental Mentors UK, 2017). Typically, it is a structured and supportive approach aimed at addressing identified deficiencies and ensuring that practitioners can continue to provide safe and effective care (NHS Resolution, 2023).

In the GDC's use of the term, remediation refers primarily to action taken by a registrant which can be considered as a mitigating factor at the adjudication/hearings stage. It can also be considered at the case examiner stage, in determining whether there is a real prospect that the registrant's fitness to practise is currently impaired. A registrant may also take earlier action, for example on learning of a concern, but this would fall without the formal FtP process.

At the case examiner stage, an investigation can result in 'undertakings' being agreed with the registrant. Undertakings are offered by the case examiners and agreed with the dental professional as an alternative to progressing to a hearing. They can involve a commitment to undertake training in a specific area of clinical practice.

'Conditions' can be imposed on a dental professional's registration following a hearing, if their fitness to practise is judged to be currently impaired, and their practice needs to be restricted to protect the public or in the public interest. They can also be imposed whilst an investigation is ongoing to protect the public or it is in the public interest (or the registrant's own interest) to do so.

Undertakings may have some similarity to remediation, for example where additional or remedial training is indicated, and so 'remediation' may be used to refer to action taken following an

investigation which reflects an improvement in an otherwise deficient area of practice or behaviour. However, when discussing the formal context of the GDC's FtP processes, we will reserve remediation for action taken voluntarily before an investigation is completed: remediation as mitigation, rather than as an outcome. This distinction is important with regard to timing of action and its role within the FtP process.

Further details are provided in Box 1 at the end of this section but, in brief:

- Remediation focuses on voluntary personal corrective actions before or during an investigation.
- Undertakings are agreed with registrants but binding for early intervention after an investigation.
- Conditions impose specific limitations or requirements on a registrant's registration following a panel or hearing at the end of an investigation or whilst an investigation is ongoing.

The need for remediation may arise for various reasons, such as clinical errors, communication issues, ethical lapses, or challenges in maintaining up-to-date knowledge and skills. Rather than punitive measures, remediation focuses on education, support, and professional development to help practitioners overcome their challenges.

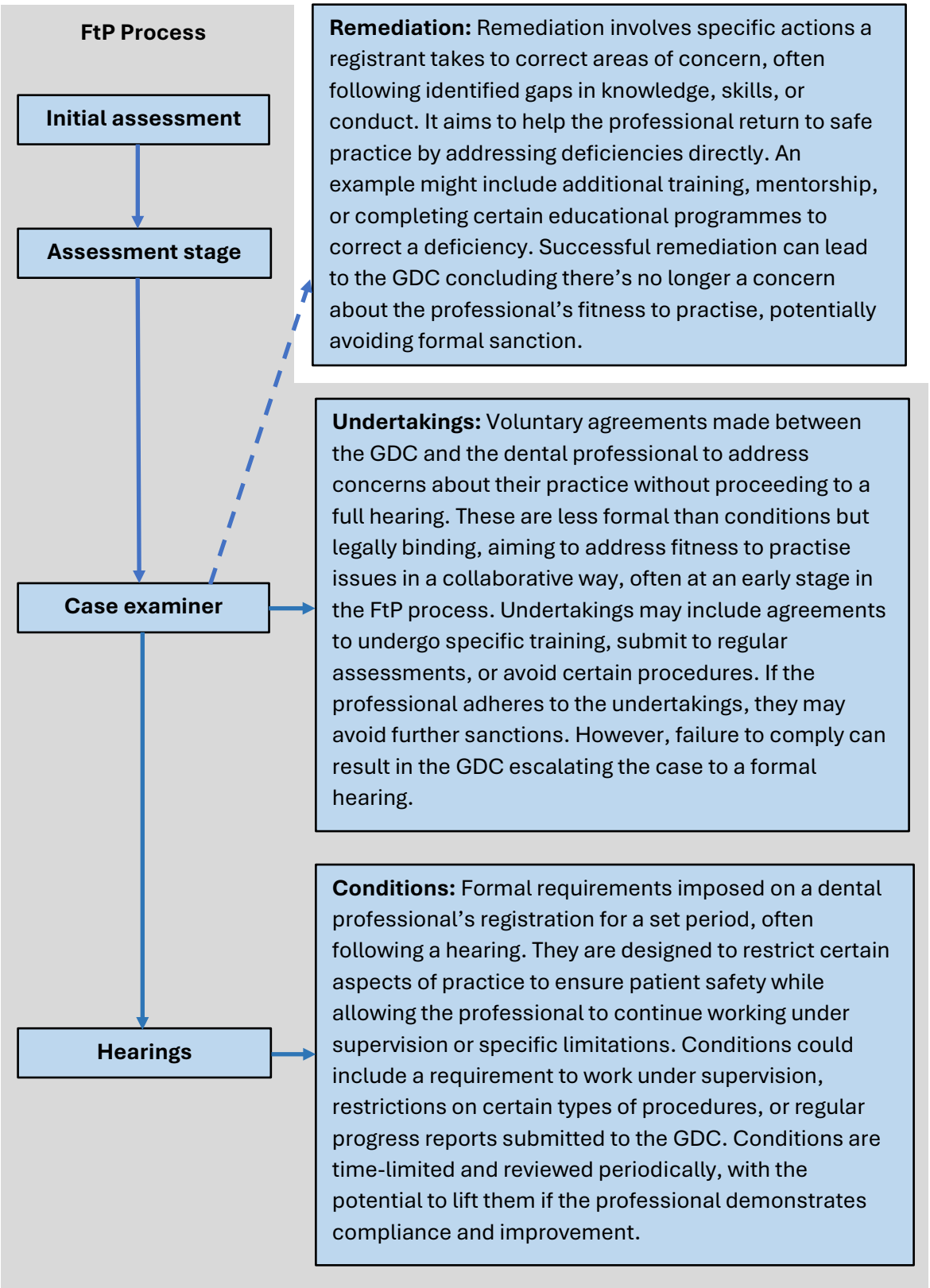
The remediation process typically involves a thorough assessment of the individual's performance, identification of specific areas that need improvement, and the development of a tailored remediation plan. This plan may include additional training, mentoring, supervision, and ongoing evaluation to monitor progress (COPDEND, 2015).

Remediation is a crucial component of healthcare regulation, as it seeks to balance the protection of the public with the recognition that professionals may face personal or professional challenges that impact their ability to practise effectively (COPDEND, 2009, in GDC, 2015). The ultimate goal is to support healthcare practitioners in reaching and maintaining the required professional standards, ensuring the delivery of effective and safe patient care. Importantly, healthcare regulation must also satisfy the need to maintain public confidence in the profession, and it may be the case that remediation steps, which would otherwise satisfy a regulator's test of current and likely future impairment, may still fail to address the broader issue of public confidence. Any judgement of the effectiveness or suitability of remediation as mitigation will be made in this context.

Despite remediation being used in health care systems globally, there is limited evidence for the particular models or strategies employed (Price, 2021). Literature is limited, with the majority coming from medicine in North America (Price, 2021). Further, what is not well understood is how remediation is applied by regulatory bodies and what potential it has to feed into earlier decision making, moving from punitive to supportive regulation.

Box 1: Definition of terms

The GDC uses remediation, undertakings and conditions to address concerns related to a registrant's fitness to practise. These are summarised below in relation to the progressive stages of the FtP process. Note that remediation may also be initiated by a registrant outside of the formal process.



1.1 Aims

The aim of this research was to provide evidence to inform the GDC's approach to early remediation, the potential for it to be included in case decision-making at an earlier point in the process (before the Case Examiner stage) and how it might be evaluated going forward, by addressing the following:

1. How regulators in health and selected non-health sectors operate, manage and evaluate their approaches to remediation; how this compares to the GDC's current approach and what learning there is for the GDC.
2. From the perspective of GDC staff, exploring:
    a. what is working well and what is not,
    b. what 'better' might look like and, if needed, what the GDC's journey to 'better' would require.

2 Methods

2.1 Ethics

Ethical approval was granted by Newcastle University (reference: 38982/2023). Interview participants were asked to give informed consent having been provided with a comprehensive information sheet detailing ethical considerations including: the aims, nature and purpose of the research; the voluntary nature of their participation; their right to withdraw; arrangements for recording, holding and deleting data; the steps taken to ensure anonymity and the limited, serious conditions under which this might have to be compromised (e.g. issues suggesting fitness to practise or safeguarding concerns).

2.2 Documentary analysis

A documentary analysis was undertaken to understand and inform the GDC's current approach to remediation. This included comparable regulators' approaches to remediation, identifying areas of learning including any best practice, and existing or potential approaches to monitoring and evaluation.

Documents were identified through relevant organisational websites, through targeted emails to key stakeholders, and through a limited rapid literature search. Synonyms were also considered, including: 'remedial', 'conditions', 'undertakings', and 'revalidation'.

2.2.1 Scope – what counts as evidence?

The following document types, if published between 2015 and 2024, were considered to be within scope for the rapid review:

- Internal GDC guidelines, workflows.
- User literature.
- Websites, social media and YouTube.
- All modes e.g., written, oral transcription, video, audio, etc would be considered, where relevant.

2.2.2 Analysis and synthesis

Our documentary analysis was guided by a number of questions, which would also inform the construction of our interview guides:

- What is remediation?
- How is it defined/described?
- What guidelines exist for consideration of remediation as part of FtP or similar process?
- Where do examples of good practice exist?
- How are key messages communicated to stakeholders?

Documents were analysed according to the following protocol:

- Documents identified (searches of websites, referral from colleagues at regulators, literature searches).
- Documents classified as relevant, irrelevant, or potential/uncertain.
- Filtered documents reviewed and logged.
- Key findings distilled from document.
- All notes analysed and key findings synthesised.

Synthesised data were then used to inform the subsequent interview schedules.

2.3 Qualitative data

Interviews were undertaken with relevant GDC staff, identified by GDC. Those interviewed included members of the following Directorates:

- Regulation.
- Strategy.
- Legal and Governance.

A focus group discussion was held with all relevant GDC colleagues to sense check interim findings from the internal stakeholder interviews. This also served as a checkpoint before approaching external stakeholders. Twelve GDC colleagues attended the focus group.

Further interviews were conducted with a range of stakeholders including healthcare and non-healthcare regulators, defence unions and legal representatives who had previous experience of the GDC's and other regulators' FtP processes.

Qualitative data analysis took the form of reflexive thematic analysis, after a model described by Braun and Clarke (2006). Interviews and focus groups were recorded and transcribed verbatim. Researchers familiarised themselves with the transcription data by reading and re-reading the transcripts and noting down initial ideas. Themes were developed deductively, informed by the documentary analysis, and inductively, from the transcript data. Several rounds of discussion were held amongst the researchers to clarify themes, which were then captured in a database alongside illustrative quotations.

Sampling was purposive i.e., we deliberately sought stakeholders who could offer an informed perspective on the research questions (Tracy, 2020). We also used snowballing – an approach to purposive sampling in which participants who fit the research criteria suggest colleagues or personal contacts whom they believe are similarly qualified to address the researchers' questions and likely to want to participate (Tracy, 2020). We were cognisant of intersecting identities and protected characteristics as we recruited.

Participants were offered face-to-face or online interviews/focus groups, but all were conducted online.

3 Results

3.1 Overview of findings

In total 25 interviews were conducted: 15 interviews were conducted with GDC colleagues and 10 interviews were conducted with other regulators and indemnifiers. For anonymity, we are not reporting on the individuals who have participated. It is worth noting that many participants have been employed across a range of regulators within their careers and were able to compare and contrast approaches.

3.1.1 Documentary analysis

A number of relevant documents were identified (see Appendix 1). Our analysis revealed the following broad themes, which were fed into the interview question schedules:

- Remediation as a response to identified underperformance;
- Remediation as a structured process, often including supervision and monitoring to ensure that pre-determined objectives or outcomes are met;
- Remediation as a punitive process, associated with professionalism breaches and disciplinary procedures (including undertakings, conditions placed on practice, and sanctions);
- Remediation as a potentially stigmatising process, through association with concepts like 'poor performance' and 'dental registrants in difficulty,' and with processes such as FtP;
- Remediation as a multifaceted concept, encompassing a wide array of possible development activities;
- Remediation as potentially overlapping with, or similar to, the established CPD cycle;
- The cost of remediation impacting differentially on different dental professions;
- Support for remediation showing geographical variation, with the existence of a range of national, regional and local schemes for dental practitioners;
- Professionalism breaches being considered variably remediable/not remediable, with attitudes or conduct that undermine public trust in the profession being deemed unremediable;
- Remediation of conduct being potentially achievable in circumstances where remediation of an outcome may not be attainable.

3.1.2 Qualitative analysis of interview transcripts

We report six themes, with sub-themes, summarised below and in Table 1: conceptualising remediation; the legal context of remediation; acceptability of remediation; operationalising remediation; barriers to meaningful remediation; and the way forward.

Table 1: Themes and sub-themes from data (*shared sub-themes)

Theme	Sub-theme
Conceptualising remediation	– Remediation is the right direction of travel – Appetite to consider remediation straight out of the gates – Meanings of remediation – Remediation aims and outcomes – FtP and remediation… punitive or developmental? – Remediation needs to be fit for purpose
The legal context of remediation	– Case law
Acceptability of remediation	– Patients – Indemnifiers – Registrants
Operationalising remediation	– Not all remediation carries equal weight – The power of reflection – The differential opportunities to remediate – The power of reflection
Barriers to meaningful remediation	– Adversarial cultures… FtP as an extension of criminal law – Keeping your powder dry – Lack of trust – Challenges for registrants – Lack of representation* – Support for DCPs* – Lack of self-awareness*
The way forward	– Lack of representation* – Support for DCPs* – Lack of self-awareness* – Cultural change – The need for legislative change – Other salient recommendations

Below, we report each theme, and associated sub-themes, in full, with illustrative quotes to support our interpretation of the data. Quotes have been fully anonymised to protect participant confidentiality.

3.2 Conceptualising remediation

3.2.1 Remediation is the right direction of travel

There was a clear consensus amongst the GDC interviewees that remediation is the right direction of travel. The rationale for this was that the process would be: (1) time efficient, (2) fair to all parties, (3) in alignment with other regulators, (4) would instil greater confidence in the GDC from the perspective of registrants, and (5) will enable only the most serious cases to go forwards.

The GDC view was supported by the other regulators, all of whom are routinely considering remediation as part of their FtP processes, and by legal representatives, who saw it as being in everyone's best interests to close appropriate cases as early as possible.

> *"I think it's for us as regulators to try and create a safer space so that there's kind of earlier engagement [...] without prejudice [...]. So that kind of defence unions feel that they have greater freedom to kind of encourage openness and reflection at the earliest stage of an investigation."*

> *"in terms of when we consider it, it's an ongoing part of the process. And it can make a massive difference in some cases. What I'd say is when we first start an investigation, we always, unless there's a good reason not to. So we would tell the professional involved that this is the kind of regulatory concern we're looking at and they're not under any obligation to respond at that stage. But we try and encourage them to engage with us in terms of saying, you know, what might your response not necessarily response, but would you like to give us your version of events?"*

3.2.2 Appetite to consider early remediation straight out of the gates

The GDC demonstrated a unified vision to consider remediation at the earliest possible opportunity, namely at the Assessment Stage.

> *"There is an opportunity, of course, for remediation to take place as soon as a case comes through our door because defence organisations will identify. This has happened, "the our client has told us this". We [GDC] think it may be worthwhile to start looking into remediation before we ever get anywhere near case examiners, because the likelihood is if I can get to the stage of being case examiners and we can show the remediation has already taken place, then the likelihood is that we're not going to go any further."*

> *"And [early remediation] that's really important for us to fulfil our regulatory function. But on the other hand, where there is time it is because cases are moving through different stages we should be encouraging remediation as much as possible and then take that into account. So we should be encouraging people to submit any evidence of remedial action."*

That being said, there was apprehension that there would be little support from the Professional Standards Authority, as well as from bodies supporting patients.

> *"I think the Professional Standards Authority is extremely risk averse and patient bodies probably would think it's a 'get out of jail free' card for registrants, potentially."*

3.2.3 Meanings of remediation

Remediation was variously defined by regulators. Some colleagues made clear distinctions between remediation of a registrant's professional conduct, attitude, knowledge or skills, and remedial *treatment* i.e., repairing any harm done to patients clinically. Others conflated terms such as: remedial, remediation, conditions, undertakings, and revalidation.

> *"[Remediation is] any activity that demonstrates their learning and prevents recurrence"*

> *"...so I think it's important to, um, distinguish remedial activity from remediation as well. So that's a useful starting point. So okay, if you make a clinical error, for example, I don't know, [...] you scratch a tooth, uh, while you're doing something and then you go*

and fix that damage that you've caused. Um, I would call that remedial work, and I would not I would not consider that to be remediation. And that's an important distinction because, um, we're not allowed to...we don't have a process to consider remediation until case examiners."

Furthermore, other regulators cautioned against using the term 'remediation' at all, instead preferring terms such as 'strengthening practice' or 'risk mitigation'. There was a perception that the terminology can have implications such as the process being deemed tokenistic or punitive.

"We [other regulator] changed the word remediation to strengthened practice."

"I think we need to move away from talking about remediation...I know it's a handy shortcut, but in reality it is about risk mitigation."

"Remediation is a dangerous term."

"We don't really tend to talk in that sort of language of remediation here [other regulator], but effectively it means the same thing. It's, are we satisfied that we've been provided with the information about risk mitigation for the future, to avoid repetition and to satisfy public interest?"

"I think using terms like remediation, [...] sort of reinforces the slightly more tokenistic approach to it. It's kind of like, I'll do these courses, I'll produce these certificates. Therefore, I've demonstrated remediation when actually we're looking at holistically ongoing risks"

There was a perception that imposed sanctions on practice, namely conditions and undertakings, are enforced remediation. Enforced remediation is the use of restrictions to mitigate risk.

"I think remediation is something that someone offers, that someone does and offers rather than is, is forced to do."

"I think now, um, conditions and undertakings, both sanctions that we can, um, offer or impose upon people's practice. I think in certain respects, they effectively are enforced remediation. Because, uh, you know, those sanctions are required. Those restrictions are designed to mitigate risk by limiting practice until such a time as someone is sufficiently fit to practise that they don't require those restrictions anymore."

3.2.4 Remediation aims and outcomes

There was a clear articulation of the need to ensure that the aim of considering remediation was unambiguous.

"I mean, the name of the game for us, and in thinking about this is to ensure and maintain patient safety. And, um, uh, my view in particular is that how better to do that, to have a registrant that's remediated, you know, they've they've fixed the issue, um, before it becomes a real problem. So that that's why we would like to get it as early as possible within the fitness to practise process."

"So it's really important that as many cases as possible are dealt with as quickly as possible and as fairly as possible, obviously without the sort of, you know, could make sure the quality is right, but they need to be done as quickly as possible."

This is important, as protracted FtP processes can have implications for registrants' finances and their mental health:

"And certainly when you're dealing with, when you start acting for private paying clients [...] it really focuses the mind on the critical need to try and resolve things without a hearing, because [...] for them to try and fund the defence at like a 5, 10, 15-day hearing...It's catastrophic."

"Our approach is always to try and get the thing shut down as early as possible, not just because of the finances, but [...] I'm sure you don't need me to tell you about the catastrophic impact of fitness to practise proceedings on people's mental health and having had clients and who, you know, who have died by suicide..."

3.2.5 FtP and remediation...punitive or developmental?

There was a consensus that remediation ought to be a development process, and not regarded as punitive by registrants.

"Whereas our process is designed to determine whether or not someone is fit to practise, it's not designed to, um, you know, yeah, it's designed to impose sanctions on people, to make patients safe, basically, rather than to incentivise, improve performance."

"The point we're trying to get to with registrants is, this isn't a punitive process and it's not punitive. So, if you have done all that you can, you've remediated yourself back to a good level, we should not arbitrarily then be giving you a sanction, on top of that, simply, you know, to punish you again for a mistake that you've rectified."

"I mean it is it sort of punitive, I suppose. It certainly feels that way if you've been in tears. I think with clinical matters it really is making sure people giving people the opportunity to get back to practice and that's the way I think I see it."

3.2.6 Scope of remediation

There was consensus as to the scope of the issues that could be considered as remediable. This includes: deficits in clinical skills, knowledge, and communication or record keeping. Issues that are underpinned by either deep seated attitudinal issues or behavioural issues were unanimously deemed out of scope. These included, but were not limited to bullying, racism, misogyny or sexual harrassment. Colleagues provided examples of the considerations that would need to be made:

In scope examples:

Drugs and Alcohol: *"a person attending an AA or a Cocaine Anonymous, all those other groups and undertaking a programme. [Following] the steps within the programme and the attendance and, um, but that would normally be for people who want to want to, you know, um, give us information that would normally be supported by the individual undertaking drug testing, alcohol testing on a regular basis and giving us that information."*

Clinical matters: *"if it's a clinical matter, remediation can be around making contact with organizations like Dental Mentors UK and arranging a mentor for yourself to look at behaviors but also getting somebody to support you and monitor the way that you do certain clinical items so that the clinical item that we're looking at, you've already started to look at that and you've got support or you've undertaken CPD in relation to that specific item."*

Out of scope examples:

Racism: *"There's case law that suggests that deep seated attitudinal views are very difficult to remediate. If you're a dyed in the wool racist, then, you know, going on a two-hour EDI course probably isn't going to make you not a racist anymore."*

Conduct: *"an individual's, conduct sometimes, particularly where you've got an individual who is showing racist, sexist or commit sexual acts on individuals. So that's a really difficult one. And I've very rarely seen, seen, seen remediation in relation to that".*

While attitudinal and behavioural issues were deemed non-remediable, they were considered within scope for evidence of mitigation.

"If I was the decision maker and I was saying to myself what evidence is there of remediation in these circumstances and say it was sexual misconduct or something along those lines, I don't know what evidence somebody would be able to produce of that. I think they could certainly say I've reflected on my behaviour and you know, I, you know, I realised that recognise that it was poor and below the standard one would expect and I'll be really mindful of this and that sort of thing. And I think all of that is mitigation."

Dishonesty and sexual misconduct: Other regulators reported being "hawkish" with respect to behavioural and attitudinal complaints, particularly those relating to sexual misconduct. However, differences were described with respect to whether these issues were in scope for remediation. Some regulators perceive that there is scope in the process for remediation of more psychological or behavioural issues (including dishonesty, sexual abuse) and will accept evidence such as psychiatrists' or psychologists' reports, or evidence of engagement with Cognitive Behavioral Therapy (CBT). However, panels become "twitchy" when considering such evidence despite it being permissible. Any such reports need to be evaluated by experts as to whether they reflect sufficient/necessary addressing of problem. The key issue is that there is lack of evidence in the health and psychology literature as to the effectiveness of any such interventions, something which fed into panel anxiety.

"We do very occasionally have psychology reports to show that a person has taken the correct psychological steps to admit to dishonesty, address that through some form of therapy or cognitive behavioural therapy and now they appreciate why they what they did was wrong and why they did that and how they would take steps going forward. But given that I think there is very limited awareness or maybe even research I don't know, into that area of whether someone's behaviour. Yeah, I don't. If they are, you know, if they are, have sexually assaulted someone, whether or not therapy can alone can address that problem."

"I think the committees are reluctant sometimes to accept these reports or this evidence [CBT] on face value and so there is still that thought that that kind of behaviour is very tricky to address."

Regulators said that in such cases, they closely align their decision making to current case law.

"So case law, just as an example, case law is very kind of hawkish on things like dishonesty."

"We're kind of we're still, we're still where case law is and I think that's right, which is that you give limited weight to remediation in certain types of cases. So sexual stuff, we're very rightly very hawkish."

Other participants took a more nuanced view of issues of dishonesty, sexual harassment, and cultural bias (e.g. racism or homophobia), and even pointed to case law as proof of this.

> *"So a good case that I would really recommend you to look up is one called PSA against the HCPC and Roberts which was a case that went to the High Court in 2020 [...] That was a case where the registrant had made a racist remark and they had fully remediated. It was a racist comment made on one occasion when they were a very junior paramedic and when they were working in a team where that comment was that phrase because it was a phrase, the three letter phrase was routinely used and they had had picked it up from there."*

3.2.7 Remediation needs to be fit for purpose

Remediation is not a single act; time is required for areas of deficit to be remedied. There is a period of development and consolidation required in order to truly evidence that remediation has occurred.

> *"...making sure that things are bespoke to the registrant in question and at the timing as well. You know, there are certain skills which just take time to develop. And going on a course is not necessarily going to sort of I think we've got to be careful about what we're convinced of as remediation."*

> *"So [registrants need] enough time to acquire, develop, acquire the new skill through training, but then also no pun intended to kind of cement it through repeated practice and so on and so forth."*

> *"[hypothetically]...I'm a registrant...say you have a concern raised against me because I didn't do a crown properly. Is it enough to just say, well, I've gone to, you know, a two-hour course on crown preparation? Is that really going to change my, my behaviour? And actually for registrants to engage meaningfully in, um, sort of development programs, training whatever to, to change their behaviour. We've got to give them enough time to do that. So it's sort of, you know, they might want to find a course that really is specific enough to meet their needs and it's sort of how that runs alongside the set process."*

Further, behavioural issues, including addiction, require time to address dependencies.

> *"Some other items behavioural items drugs drink alcohol so on can take a lot longer. But there is a there may be a point within that where that individual becomes safe to work even though they are still going to AA, Cocaine Anonymous and all the other things that go with it."*

3.3 The legal context of remediation

3.3.1 Case law: Remediation as evidence of current impairment

Case law was established with respect to consideration as to whether a registrants' current FtP is impaired. The case in question was Cohen v. GMC [2008] where a court found in favour of the registrant. Cohen argued that the FtP panel should have focused on his current and future fitness to practise, and not disciplined past misconduct through sanction. If mitigating factors had been taken into consideration, current and future fitness to practise would not have been found to be impaired.

Following this ruling, as well as two further appeals where remedial action was deemed important, remediation was given more weighting in decision making. Zymunt v. GMC [2008] and Azzam v. GMC [2008] further affirmed the case law, with the rulings stating that FtP panels must consider any

aggravating and mitigating circumstances. Importantly, this includes panels considering any remedial action undertaken since the incident under investigation, when reaching decisions on impairment.

Referred to as the Cohen Factors at the GMC, and also adopted at the NMC, the following questions are utilised as indicators of current impairment:

- Can the concern be addressed?
- Has the concern been addressed?
- Is it highly unlikely that the conduct will be repeated?

A further high court ruling, Professional Standards Authority for Health and Social Care v Health and Care Professions Council, Roberts [2020], reaffirmed that impairment is a present tense judgement, and should look forward, not back.

3.3.2 Case law: Balancing remediation with public confidence

Although case law has clearly established the importance of considering whether a registrant has remediated and is currently safe to practise, regulators should take heed of the case of the Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council & Anor [2011] EWHC 927 (Admin).

CHRE appealed a decision of the Conduct and Competence Committee of the NMC that the registrant Grant, was guilty of misconduct but that her fitness to practise was not impaired as she had addressed the issues identified as having caused the misconduct. The case was referred to the Administrative Court as it considered the Committee was unduly lenient in its findings.

> *"Remediation and one of the things that they said, which I think is quite important, they said you can - the court when they appealed it - the court said it is relevant, the timing and the nature of the remediation. So in that case she did nothing for like 2 years and then a month before the MP, the NMC hearing, she did a couple of, she did a couple of courses…And I think there's something to be said about the genuineness of your remediation and the genuineness of your reflection."*

The Administrative Court upheld the appeal, emphasising the importance of public confidence in the profession and public protection when determining the issue of impairment. In her summary, Mrs Justice Cox referred to the judgement of Mr Justice Silber in the case of Cohen vs. General Medical Council [2008] and the judgement of Mr Justice Mitting in the case of Nicholas-Pillai vs. General Medical Council [2009]. In these cases, emphasis was placed on the registrant's current fitness to practise, which will involve consideration of past misconduct and any steps taken to remedy the misconduct. However, Mrs Justice Cox went on to say that it is essential not to lose sight of the fundamental considerations emphasised by Mr Justice Silber in Cohen: that is the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession. She further added that the panel should generally consider not only whether the practitioner continues to present a risk to the public, but also whether public confidence in the profession would be undermined if a finding of impairment were not made.

Thus, from the case law examples highlighted in the sections above, remediation should be given consideration in FtP determinations. However, deeming conduct to have been remediated must also be balanced with any potential disrepute of the profession, and with public confidence in the processes.

3.4 The acceptability of remediation

3.4.1 Patients

The majority of respondents felt that there would be little acceptability of remediation as an outcome of a complaint, particularly on the side of a patient.

> *"Patients won't go for it [remediation]. They want their pound of flesh."*
>
> *"...patients often don't accept those outcomes as well because I think they don't necessarily understand what we're here for. "*
>
> *"90% of our informants just want their pound of flesh and they're never going to accept anything other than, you know, their pound of flesh. If we would say they've accepted wrongdoing, they've done this, they've done this, they've done this and they've remediated. Now we'll sort of appeal the decision because they just want that person to be kicked. You know, they want that person to be struck off."*

However, some participants felt that patients are more invested in the future care of others than they are often credited for, and thus would accept remediation.

> *"I think patients, much like victims of crime, I think most of the time what they really want is, to know that the same thing won't happen again to somebody else."*

3.4.2 Indemnifiers

A cynical view of acceptability with indemnifiers and legal representatives was reported.

> *"You know, there's all sorts of perverse incentives in play because the indemnifiers constantly bang on to us to reduce the culture of fear. But if registrants aren't sufficiently afraid, then they won't want to pay huge premiums to be indemnified."*

There was evidence that this view may have been well-founded, historically:

> *"Years ago [...] I was at a big firm that doesn't even exist now [...] Basically, they weren't that keen on my attitude of throwing everything at case examiner stage because all of our work was funded by insurers and so they were like, let it go on to a hearing, we get paid for 10 day hearing."*

However, the contemporary ethical code of conduct that binds legal representatives was referenced as a counter to such views.

> *"You know, solicitors are bound by codes of conduct and have to behave in the right way and. By far and away, the lawyers that I know for the vast majority of them are, you know, would be working to their clients' best interests and putting that at heart. I don't see solicitors, you know, extending things unnecessarily, although there will always be some, I'm sure, but we have no evidence of that. I have not seen anything like that."*

As one solicitor put it,

> *"We have a very, very, very high rate of cases being shut down at case examiner stage and that's what we always aim for."*

3.4.3 Registrants

The acceptability of remediation amongst registrants, particularly sharing evidence of early remediation, was felt to be largely down to two key factors – the extent to which registrants perceived

remediation to be an admission of culpability in circumstances where they might wish to argue their case; and the degree of trust that registrants might have in the GDC.

> *"It's whether, whether would, somebody would see it as blame. I suppose it's how you present it, isn't it? If you're accepting blame if you're accepting that, yes, you've missed something."*

There was a perception that registrants might fear that early remediation for a specific issue would be recorded as a 'strike' against them, even if it led to the regulator regarding the issue as closed:

> *"Adverse fitness to practise history is something that gets talked about. Registrants quite often have to say, we'll have to say whether they've got adverse fitness practise history, but equally they quite often have to say to indemnifiers, and probably if they're going for a job with the NHS or something, whether they've ever been subject to a fitness to practise investigation."*

> *"So yeah, it's something we'd have to look at as to what would count as adverse history, because we'd need to make it attractive for people to sign up to it because I think that's been some of the problem with accepting undertakings."*

3.5 Operationalising remediation

3.5.1 Not all remediation carries equal weight

Reflection alone was not considered to be sufficient to show that remediation had occurred.

> *"...so they can write a really heartfelt letter or, you know, reflex reflective piece where they talk about how upset they are, how sorry they are that they've missed it all. But I don't think. That that would never be enough for me, because it's part the way I would describe it is reflection is part of remediation, but it's not. It's not all of it."*

Supervised practice, or an interactive course was deemed to have more weighting.

> *"I say in in terms of clinical failings, I think stuff that is like supervised or actually is involve some degree of hands on application as opposed to just reading stuff or watching a module or whatever. So that that's obviously something of value."*

> *"I think also where it comes to conduct related issues, stuff that maybe has involved like attendance at courses and kind of group discussion or something interactive, that sort of thing. Again, rather than just kind of show and tell module that they've done online, that sort of thing."*

However, it was appreciated that there is no one size fits all fix.

> *"...they all have their limitations, but at the end of the day, just as with any other form of evidence, you know, you can only deal with what you've got. You know, nothing's going to be perfect."*

There was a reluctance to put too much weight on testimonials and letters of support, citing the need for relevance, although there was a feeling that they can help 'get a feel' for a registrant.

> *"Testimonials I hesitate to kind of mention testimonials because I don't know you can take or leave testimonials depending on your perspective, but again, sometimes you can get a feel for you know the regard someone's held within as opposed to it's just gathering kind of testimonials from friends that are supportive, for example."*

*"We sometimes get doctors who, in their remediation sends us, send us **** loads of stuff that's got nothing to do with what the allegations are. Or take another example about record keeping and they send us loads of testimonials from patients going oh, he was lovely. Well, that doesn't help us. So it's again it sounds obvious, but it has to be relevant."*

Caution must be taken when discerning what constitutes Continuing Professional Development (CPD) and evidence of remediation. The quality, timing, weight, and relevance all need careful consideration.

"I think one of the difficulties can often be the qualitative nature of it. And even with dentistry, there's so many training providers that will churn out certificates just for you looking at a web page. Um, and sometimes it's enlightening. An assiduous case examiner will actually look at some of the timings. Um, and, you know, some of the certificates come with timings of when it was looked at and how long was spent on it. And sometimes you can see things that were accessed at 23:59 on the day before the observations were due to be submitted, and it was on the web page for one minute, but it still churned out a certificate, um, which can be very different from someone that's gone to a day long course that has kind of discussion seminars, maybe some hands on training, etc. so it might look like it ticks the box for. Yeah, um, you know, professional ethics or working with integrity etc. but how much have they actually had to contribute or to absorb in order to trigger that certificate that supposedly demonstrates remediation?"

"obviously some training courses are more powerful in terms of, you know, in terms of demonstrating things have been put right than others and then effectiveness."

"And [remediation] just seems tokenistic...and it's just that kind of knee jerk response without actually thinking about what is the risk of what can I do? What action can I specifically do to manage that risk and ensure it doesn't happen in the future? And it doesn't have to be training. It doesn't have to be the kind of routine things that people sort of think they should do. Not just what they think the regulator wants to see, and by and large, they do want to see it because committees are sort of just sort of work in a reflex basis as well."

"...for example, where, you know, they'd give you a bundle of remediation. And I think a lot of it was just stuff that they were doing through regular CPD anyway. And there was stuff that you think, well, actually, you know, this isn't particularly targeted. They're basically done a lot of random modules, and it's almost like they kind of want to persuade you by volume rather than context or relevance. So I think that that is important. So, you know, you might, you might have something where there's been a fundamental issue in relation to patient consent."

"...the volume of sort of quantity rather than quality sometimes can be an issue."

3.5.2 The power of reflection

In addition to documented evidence of additional training, regulators reported on the power of registrants providing reflections in order to demonstrate insight.

"[We should] separate insight and remediation so, remediation might be forthcoming, but the insight, coupled with the remediation shows that it is genuine and honest and accepting of a mistake."

"It's understanding the quality of what's produced rather than the fact that someone can show a certificate. And I think that's where one of the things I find most interesting is not necessarily the certificates or that sort of process, but it's more what people put in, like reflection, um, and their own words of what they've learned from the experience, how they're going to amend their practice in future, how they recognise maybe the danger points that have contributed to it and stuff like that. I think that's probably more meaningful than someone having gone on a course of, uh, variable quality and to be able to produce a certificate."

"They might do the remediation, they might do the CPD, but that insight is not necessarily there."

"it's more about, you know, listening to the person's own words in terms of their understanding of what went wrong and what they're going to do differently, uh, in future."

Not everyone was convinced by expressions of remorse after the fact:

"I do think sometimes when it comes to conduct issues, I think as regulators, we're maybe a little bit too swayed by the after the event expressions of remorse and insight, when actually we should be saying, look, this kind of conduct is just so far removed then whatever you're saying now, after you've been caught, you know, we still think it's impaired fitness to practise."

Case examiners and solicitors advocated for 'trusting one's gut' when considering reflections, noting that you can often tell when they are disingenuous.

*"Sometimes you read it and you think. And you think this is just ******** [nonsense]. Like they've just said what they want to say. And that's when the kind of evidence comes in."*

Some even aired views that reflection could not be considered as remediation, only mitigation. This view tended to come from those with legal backgrounds.

"No, in my own personal opinion, because that's not remedial action, it's it's reflection, it's mitigation, it's absolutely mitigation. For me remediation is you know it is, it's an undertaking..."

The view was that reflection alone would be unlikely to sufficiently evidence that remediation had occurred.

"I'm a lawyer by profession, so I think I can see where from a legal perspective where solicitors are coming from [on reflection as mitigation only], because you can say you reflected on something but is reflection on its own going to going to leave the decision maker confident that that mistake or whatever the misconduct was won't happen again, particularly if it's a clinical case... So you know, if you remember, there's the Cohen factors: is the conduct easily remediable, has it been remedied, and is it likely to be repeated? And I think it's hard to say that just based on reflection alone that you can say it's been remedied and it's unlikely to be repeated. I think obviously it depends on the type of misconduct."

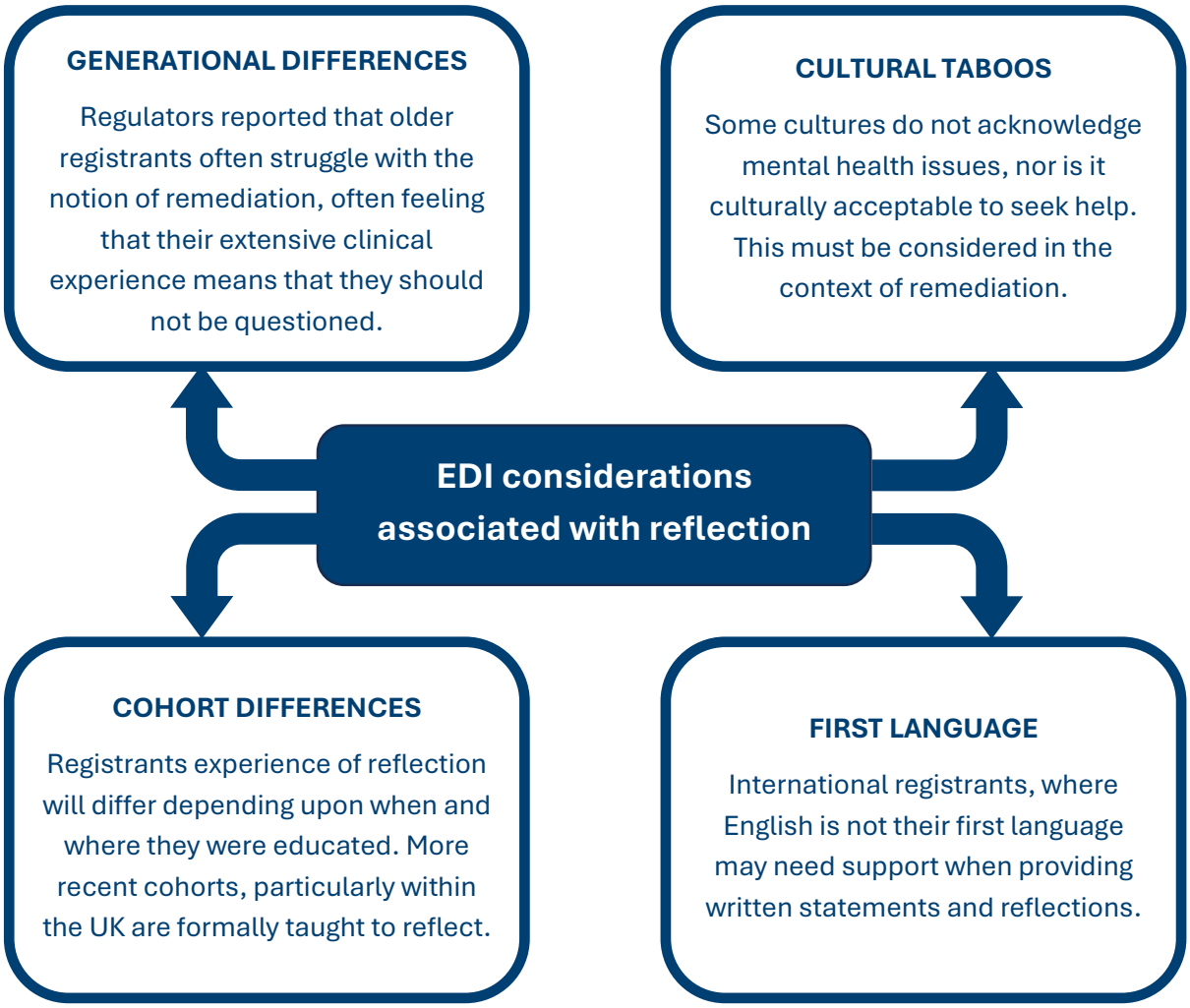
It was acknowledged that reflection could be disingenuous, and that artificial intelligence poses a threat. However, the consensus view was that from experience, you know when reflection is genuine.

"I mean the reality is no process is up to dealing with a convincing liar for example and you can have some people that very clever very manipulative that that will say what

they think think wants to be said in the way that they think won't say including kind of turning on the tears when necessary but I think generally speaking I think you. I think you can tell mainly when, when something has genuinely affected someone and they've kind of, you know, when there's been a patient death or something like that. There's reflection. I've seen where unless it's someone that's a very good actor or actress where it is difficult to fake it. I'm not saying it's impossible, but it's, you know, when there's the emotion tied in with it as well. And they talk about the impact on them and how they're reflected. It's not just going through the motion. Now, I'm not saying you can never put that on, but I think it's quite difficult."

There are equality, diversity and inclusion (EDI) considerations relating to reflection as part of remediation; these are summarised in Figure 1.

Figure 1: EDI considerations associated with reflection



3.5.3 The differential opportunities to remediate

Registrants who are working on a locum basis, for an agency, or are not employed at the time of investigation, do not have equity with respect to the opportunities to evidence their remediation. For example, the transient nature of locum work makes supervised practice difficult, as is also the case for those who are not employed. Panels must consider working arrangements when delineating their requirements for reflective conversations with superiors, and any longitudinal evidence stipulations within remediation and undertakings. There are also cultural aspects to remediation that need to be considered, for example in some cultures reflection or speaking about emotions is a cultural taboo.

Similarly, the first language of those involved must be considered – international registrants must not be disadvantaged.

> *"'Oh, I've worked with this guy since, since yesterday? Yeah, and he's great.'"*

> *"International [registrants], I think there are lots of problems with that, a there's you know obviously there's there may be a language problem to fully understand what we're asking of people. There may be cultural issues about being openly emotional, you know what? What? Whether that that's frowned upon, culturally speaking, about how you feel, particularly if you're which gender you are. That might be more frowned upon if you're male. In some cultures, I mean, to be fair, I think it probably is in most cultures, but more so in other cultures. So, I think there are lots of issues about insight if you've if you've trained in another country and the whole concept of insight and reflection are completely new to you."*

3.5.4 The importance of context

Guidance allows for context to be taken into account, for example a high risk, pressurised context will be considered when assessing fitness to practise. Whether regulatory action is taken considers likelihood of reoccurrence, so adverse consequences from unusual context does not mean action will be taken.

It was noted that under causation guidance, actions are less remediable if a registrant has chosen a course of action, 'knowingly taken unreasonable risk'.

> *"Before considering insight and steps they've taken, we need to consider the context that's important to us as well, because similarly, it might change how we look at the things they've done."*

> *"... this is the part of our decision making that is obviously that relates to we consider context as well...but we so I mean for example...if they are supposed to be four clinicians on duty, and three of them aren't at work and you're the professional who's been referred as having to work alone, and they make errors as a result of that. We will take that into account."*

> *"If they're being bullied by the line manager and there's some evidence of that, we will take that into account. If they were, for example, some see some of this might be relevant because, for example, we do, we do get referrals from, let's say, a registrant who is has been referred by a more junior colleague for being for bullying them. But actually it turns out that that they're being subjected to similar behaviour by their own line manager."*

3.6 Barriers to meaningful remediation

3.6.1 Lack of trust

The issue of trust was a recurring theme through the research, presenting barriers both explicitly, and implicitly in references to the culture around and expectations of the FtP process. This section focuses on a number of specific examples of explicit trust (or lack of) in the GDC, offered spontaneously by participants, and references to ways that the GDC had eroded the trust of registrants in recent years.

Participants were clear that trust is a necessary (if insufficient) part of the foundation on which the relationship between regulators and registrants is built. As one respondent pointed out, the quality of

that relationship will determine the success of innovations such as early remediation leading to the potential early closure of cases:

> *"One of [the barriers to early remediation] is the very poor state of relations between some of the professions and their regulators, and the GDC, unfortunately, would be one of the ones that is in that camp of having very low trust, and they do things themselves that make people not trust them, and they have to take responsibility for that."*

Participants cited examples such as the GDC's response to a High Court ruling:

> *"So I'm sure you're aware of the recent situation where one of their decisions was absolutely smashed on appeal to the High Court, and they put out a statement saying to their panels, 'Just ignore that High Court decision. We're appealing it at the Court of Appeal'.*
> *I mean that is beyond outrageous, in that unless or until such time as the Court of Appeal overturns that decision, that's a binding decision of the High Court. And so by putting out that statement, you know, what they're saying to people is essentially, we're a law unto ourselves, we don't care what the High Court says. We're going to do what we want to do, and that creates both terrible ill will and a lack of trust."*

The GDC's response to the suicide of a registrant who was under FtP investigation, and from whose inquest the coroner issued a report for the Prevention of Future Deaths (PFD), was also felt to damage trust:

> *"The GDC should consider, as part of this research and about how they respond to things is, the coroner did issue a report to prevent future deaths to the GDC just in November last year in respect of one of their registrants who died - [Registrant] – and the GDC response to that was not good.*
>
> *So, [Registrant] is a dentist who died by suicide under the... while going through the GDC fitness to practise process, and the coroner was sufficiently concerned that a report to prevent future deaths was issued [...] and the GDC's response to the [Registrant] PFD is just like just, you know, it just does not display any level of empathy or, you know, just, it's just deeply unhelpful in terms of how people perceive them as a regulator."*

Finally, the GDC's use of undercover investigators, featured in the mainstream press and responded to with significant concern by the British Dental Association (GDC 2019; BDJ In Practice, 2019), was cited as another high-profile example of conduct that eroded trust:

> *"The GDC were doing this thing where they were using retired police detectives to pose as shoppers and actually go into beauticians rather than dentists and ask them to whiten their teeth. And then would say I'm actually from the GDC.*
>
> *And I think that's, you know, it's so interesting to me that they are commissioning you guys to do research around impairment and why do people not engage with them or give them their remediation, and actually doesn't occur to them to ask, well, why don't people trust us or why don't people like us? Well, you know, take a look in the mirror lads, would be my suggestion on that."*

3.6.2 Adversarial cultures: FtP as an extension of criminal law

Tensions between the need to support registrants, maintain public trust, and the often adversarial nature of FtP were noted. This perception indicated a lack of trust in the wider process, and of the

interests of legal representatives in the system. It was posited that FtP had become an extension of criminal law, and the criminal law or prosecution backgrounds of those working in the legal teams within regulatory organisations perpetuated such a culture.

> *"...it is difficult when you then get the law involved because as we've said, you know they it's all about denial and the thing is [...] it seems that most people who work within the regulatory law world started off in criminal law. And so it has become an extension of criminal law, which means that a whole you deny everything until you know the full case against you only make admissions as much as you have to. It's...it really feeds that. So that's what we're up against. I think. I mean, most of most of my legal colleagues, all they all came from criminal law."*

> *"With lawyers who've come from a criminal background [...] what we find is that, say we'll have cases transferred to us, and that the approach has been fight, fight, fight, fight, fight and deny everything."*

> *"If you have done something and you know you've done it and the evidence is there and it's going to be proved, why would you attack [and] adopt an approach of fight, fight, fight? Because you're going to get zero credit for remorse, insight, remediation, like, risk of repetition, and so and that is something that we see as not the right approach."*

3.6.3 Keeping one's powder dry – the case against early remediation

In the context of health professional conduct and remediation, the strategy of "keeping one's powder dry" was frequently cited. This approach refers to delaying the submission of information relating to remediation until the nature of the case against the registrant is fully understood. It is often employed by defence organisations to safeguard their clients from prematurely accepting blame or undertaking remediation that may not be necessary.

One stakeholder articulates this perspective:

> *"The registrant is probably likely to want to keep their powder dry rather than sending forward information about remediation, which may or may not be required. Usually, remediation would come from defence organisations once they know the case against them, and that's fair enough. I think that's one of the limitations of our legislation at that stage of the case."*

From the registrant's point of view, it is understandable why they might avoid early admission of fault. Another stakeholder explains:

> *"I suppose, putting yourself in the shoes of the registrants, you know, why would you accept blame at such an early stage? If you keep your powder dry, you can see what the GDC case is."*

This strategy is often endorsed by defence organisations, who prefer to evaluate the evidence against their clients before deciding on a course of action:

> *"[Registrants] and their representatives think, 'Well, we'll keep our powder dry. Let's see what the [Regulator's] got.' But the [Regulator] would welcome early evidence that could mean a case is closed earlier."*

However, this delay can lead to procedural inefficiencies. If a registrant doesn't respond at the first or second stage, it forces a tribunal. The question then arises: if evidence can be presented at the tribunal stage, why not earlier? This is particularly pertinent in cases that are not genuinely disputed. The timing of remediation is crucial:

"There's a big difference between a doctor who holds their hand up at the time or soon after, accepts duty of candour, apologises, shows insight, and does the remediation, versus a doctor who a week before their hearing turns up and says, 'I've done an online course in record keeping.'"

Keeping one's powder dry may be a consequence of a different strategic approach – one that is not as simple as 'waiting to see what the regulator has on you,' but rather is down to a more nuanced appreciation of the ways that cases can progress.

In the first instance, if a registrant denies the facts, they may not merely be keeping their powder dry, but may not have undertaken any remediation:

"So, if I didn't perforate [the patient's] oesophagus, why would I do CPD about how not to perforate an oesophagus?"

However, in less obvious cases, when the facts are contested but there is a risk that they may be found proven, or that the question of impairment arises anyway, registrants may undertake remediation which is not immediately shared with the regulator:

"I mean, we literally have a hearing on today where that's the exact situation, where in that we denied all of the facts, a majority of the facts. So dishonesty for example was found not proven, and though that was, you know, obviously that's the big one, but now we're back today giving evidence because they've now gone on to impairment stage.

Well, although we've never showed it to the panel before now because we were on 'full denial,' we do actually have a load of stuff to show them about impairment because there was that risk that something might be found proved against us."

There is a possibility that this game of cat and mouse is perpetuated by the regulators themselves. As one solicitor put it:

"A lot of the time, you know, that regulators always plead their case at its highest, and they're very quick to lob in an allegation of dishonesty [...]

And I think they're far too quick to level dishonesty because it massively elevates, elevates the case, you know, and I do find that frustrating when something is alleged to be dishonest in circumstances where it's not."

Keeping one's powder dry was condemned by the GDC and other regulators, labelling it unhelpful:

"So that that perpetuates that whole be really careful what you say whereas what we want is the complete opposite of that. We want, don't be careful what you say. You know, absolutely open your heart to us. We're not going to make that won't make it worse for you. It can only make it better."

Introducing unwarranted allegations removes the potential for remediation, as the registrant is bound to contest an allegation that they believe is factually wrong, or is contestable on statutory grounds. In this circumstance, they will take the view that remediation is unnecessary, or may suggest their guilt.

For example:

"We had a case recently where somebody accepted a loan of £10,000 from the patient. So they were completely floored - they genuinely didn't see anything wrong with that, so that was the case of a very serious breach of professional boundaries, which might well be incompatible with ongoing registration. But they were completely transparent about taking the loan. There was no secrecy, and how their practice was aware of it was because they told the practice as well.

The regulator has pleaded that as an allegation of dishonesty. Where's the dishonesty you need to plead? You know, you need to plead it as misconduct, and it's extremely serious misconduct, but they will just lob in an allegation of dishonesty in, kind of, any circumstance involved in finances, for example. And I think they're far too quick to level dishonesty because it massively elevates the case, you know, and I do find that frustrating when something is alleged to be dishonest in circumstances where it's not."

The type and amount of remediation required can vary significantly depending on the nature of the allegation. A one-off event followed by subsequent good practice would necessitate less evidence than long-term issues. It is also important that the evidence presented is relevant; for instance, patient testimonials may not be helpful if the concern is about record keeping.

Undertakings (also known as post hoc specified remediation by other regulators), may be utilised in cases where there are multiple concerns across different areas of practice, but the impairment is not severe enough for erasure or suspension. These are offered to the registrant, who can choose to decline, in which case the matter will proceed to a tribunal:

"There are two separate kinds of remediation: one which helps us to decide that a doctor isn't currently impaired, and another where we think the doctor is impaired and we can say, 'It will help you to become a better doctor and it will protect patients, go off and work under undertakings.'"

In summary, while the tactic of keeping one's powder dry can be strategically beneficial for registrants and their defence organisations, it poses challenges for the efficiency and effectiveness of the remediation process. Early and relevant remediation efforts can significantly impact the resolution of cases, potentially avoiding the need for tribunal proceedings and ensuring better protection for patients, but it requires registrants and their legal representatives to be able to trust the regulator.

3.7 Challenges for registrants

Navigating the fitness to practise process can be fraught with challenges for registrants. These challenges are often exacerbated by a lack of legal representation, support, self-awareness, or awareness of the relevant professional standards (such as the financial example above) and of the FtP process. Commercial pressures can also make remediation seem unappealing. Understanding these issues can provide a clearer picture of the difficulties faced by healthcare professionals and the areas where improvements are needed.

3.7.1 Lack of representation

One significant challenge is the absence of proper legal representation. Many registrants are unaware of the necessary steps they need to take because they lack legal guidance. As one stakeholder noted:

"There are some people who don't know what they need to do because they're not represented."

This lack of representation can lead to harsher outcomes in fitness to practise hearings. Legal representation can make a substantial difference in the outcomes of these hearings. Another stakeholder explained:

"I am aware that there is a correlation between people that are legally represented and, you know, less draconian outcomes of fitness to practise hearings... And I do think and it sounds cynical, but if you have a good rep who's able to school you in terms of what you say, then you can easily impress a committee by saying the right things. Now, whether you mean it or not, no one will ever know. But they know the right things.

You know the right trigger words, things like that, that will express the remediation that the committee wants to hear."

3.7.2 Support needed for dental care professionals

Dental care professionals often require additional support to understand and comply with the specific instructions given by a committee. Without adequate support, these professionals may struggle to meet the expectations set for them:

"We find that dental care professionals need more support to try and understand what they need to do when they've been given specific instructions by a committee."

This lack of understanding can hinder their ability to demonstrate appropriate remediation and compliance, further complicating their fitness to practise evaluations.

3.7.3 Lack of self-awareness

Another challenge is the lack of self-awareness among some registrants. There are individuals who, even when faced with a complaint, fail to acknowledge any wrongdoing. This mindset can prevent them from engaging in necessary remediation unless they are explicitly compelled to do so:

"There is always a difficulty with people who will get a complaint about them, but then will never admit or in their own minds that they've done anything wrong. And I never do anything wrong. So they're not going to remediate unless they're forced to do something."

This lack of self-awareness can be a significant barrier to the remediation process, as it prevents registrants from taking proactive steps to address the issues raised against them meaning that cases are likely to have to progress to full hearings. This results in protracted timelines, cost implications, as well as having emotional and professional implications for all stakeholders involved.

3.8 Professional culture and commercial priorities

Regulators detailed their experiences of working with registrants who practise in a commercial context. Points were raised that commercial imperatives may change the approach to remediation – 'time is money', and so time spent in remediating activity may be seen as reducing income, and so lead to less engagement.

"They might do the remediation, they might do the CPD. But that insight is not necessarily there because I think time is money."

"I feel that if somebody is more commercially minded in that they're running a business…and so investing time into thinking, you know, how do I embed this learning should I. For example, individuals might go to hospitals for free to supervise in their free time at weekends, to supervise certain clinicians, not to supervise, to be under supervision from a certain clinician, to actually embed that learning. The insight that they, you know, really value this profession and career, whereas the commercial aspect is just that, it's just kind of get through this and I've not got time to waste basically." (*changed to clinician to anonymise)*

3.8.1 Engaging in remediation is seen as an admission of guilt

There is a perception that engaging in remediation is an acceptance of guilt, that an event occurred, that it is undisputed.

"So I've had this conversation with dentist defence unions. They think if they provide remediation now, it's an admission of guilt. It's an admission of guilt. Then they've locked themselves into a narrative for when he goes to Rule 4, they can't - once they get the full bundle - they can't then deny the allegations because they've still they've remediated. So they've almost admitted the allegations are proven. So Rule 3, they won't provide you. And because they think it's locking them into the narrative that we've admitted liability."

This view is not necessarily shared by all lawyers:

"To my mind, I don't think it's an admission of guilt or an acceptance of anything. It's it goes to, I think, it's to the point of insight, and also there's things that we would say, for example, you can we would frame it in a sense that the registrant is obviously devastated to find themselves before their regulator and disputes the account given. However, because this has been raised, has taken steps to ensure there are no issues in any event. So you, you kind of say, look, we don't agree with it, but even if you are against us on that, we've done this anyway because we want you to be reassured that there's no issue here."

There are also unintended consequences, such as consequential employment tribunals, that mean employers and unions may advise registrants not to remediate at an early stage, but instead wait for a hearing.

"Accepting someone has bullied means there is an employment tribunal as a consequence so there are implications with employers."

3.9 The way forward

3.9.1 A cultural change is required

Many shared the view that before considering the nuts and bolts of remediation, a culture change is required. Organisations need to be willing to close cases at early stages, and not shy away from such decisions.

"I think maybe there's a little bit of work they [the GDC] need to do culturally to accept that you can close things down at the front end. I think generally there's been a bit of a hesitancy to close things down before statutory decision makers, i.e. case examiners or fitness to practice hearings."

One regulator described this as taking a "risk positive" approach, to contrast the mindset with the more commonly encountered regulatory orientation of risk aversion:

"We take probably opposite to the GDC we over the last year or so we've just we've turned and taken quite a risk, risk-positive approach. So, we are trying to deal with, you know, if you've got everything you need early on, then we're trying to sort of close down those cases earlier on in the process rather than run them the whole way through."

Furthermore, there was a perceived need to move away from the adversarial culture.

"I think we'd probably have to move away from this adversarial setup in order to get true safe space remediation, insight, learning."

The need for a cultural change is not limited to the GDC. The perception of defence bodies varies across professions and appears to be culturally determined. Historically, this has been reported to

lead to a more adversarial culture with negative impacts. Change will require consent from registrants (who have 'no respect' for their regulator), and defence bodies ('who are very aggressive').

> *'I feel like it's easier for defence bodies [to] be more aggressive if the regulator isn't respected by the profession.'*

> *'They can be quite aggressive in their tactics and it's very it's very tactical. I think it would be a good thing for regulation to move away from this real adversarial approach, like a criminal law setting, like us against them.'*

3.9.2 The need for legislative change

It was held by some that in order to consider remediation earlier in the process, legislative change was required. Further, it was the belief of respondents that the government are unlikely to prioritise such changes going through parliament.

> *"So the government can move quick quickly when it wants to, but but it is, but it changed to Rule 3 or you know one particular rule here and there is going to be part of the bigger part. They're [government] very reluctant to let regulators jump the queue."*

> *"But we know that in the process or in the plan for regulatory reform, we [healthcare regulators] are much further down the queue. So we have got our list of things that we would like to see [legislative change] and that's what we pressed for. And this [earlier consideration of remediation] is one of them. It's very unlikely to be introduced until we actually get to wherever we are on the list."*

Other regulators are using the delays in regulatory reform as an opportunity to review their processes and consider public perceptions of such, as well as review their practice against established case law.

> *"...because of regulatory reform that's coming through [we are] taking it as an opportunity to just check that we're in the right place on things like public confidence cases."*

There were mixed perceptions amongst GDC colleagues as to whether considering remediation at an early point in the FtP process required legislative change or not.

> *"I'm not entirely convinced that we would need legislative changes, more policy, a policy decision, because I don't think the legislation for case examiners specifically mentions, uh, remediation. It's just representations made by the registrant. No, there is a potential issue with dealing with remediation earlier in the in the process, which is decision makers before the case examiners are lay people. So, you know, if we are to adopt this earlier on in the piece, we would need very clear guidance and instruction on what good looks like in terms of remediation."*

3.9.3 Building and maintaining trust

Returning to the theme of trust, participants were clear that the success of any venture to engage registrants in early remediation would require trust to be built between the GDC and registrants:

> *"I think the GDC would need to foster a culture where there isn't mistrust and the problem they have at the moment is that if they say to lots of people or, you know, 'Give us your remediation early and we'll take it into account fairly,' the response from a lot of people would be well, you're not fair and we don't trust you because look what you did over that High Court decision.*

So, I think the GDC needs to, and this is true across lots of regulators, but the GDC is quite bad at the moment, that they need to understand the wider impact of their actions when they do things like that [...] it erodes trust and has a very negative impact on people's willingness to engage with them."

Furthermore, there was an appreciation that regulators needed to trust that defence unions are acting within the best interests of their clients.

"I'm of the view that as regulators we need to understand the role of a defence union and what it is that they do. And you know, sometimes people express frustration to me because they will think that the [defence union representative] is being difficult or, you know, particular representatives being difficult on a particular case, you know when I'll say to them, but they're doing their job. That's what someone's paying their subscriptions for. They're they're acting in what they believe is a person's best interest. Now, whether or not you think that is in someone's best interest is, is, is immaterial. But ultimately they're there to defend someone. It's like a prosecutor complaining about defence lawyer, you know, their job is to defend the interests of their client, et cetera."

4 Discussion

4.1 Aim and key findings

The aim of this research was to provide evidence to inform the GDC's approach to remediation, including the potential for it to be included in decision-making at an earlier point in the FtP process and how it might be evaluated in the future.

In doing so, we addressed the following questions:

1. How do regulators in health and selected non-health sectors operate, manage and evaluate their approaches to remediation, how does this compare to the GDC's approach, and what learning is there for the GDC?
2. Where are the GDC currently on remediation? What is working well, and what is not?
3. Where could the GDC aspire to be in the future? What might 'better' look like? If improvement were needed, what would the GDC's journey to 'better' involve?

Our findings indicate a broad consensus among GDC staff and stakeholders, including other healthcare regulators, that remediation is a valuable strategy within contemporary regulatory practice. There is significant support for incorporating remediation earlier in the FtP process, ideally at the Assessment stage, although there are varied opinions on what is remediable, what constitutes effective remediation and what barriers to its implementation exist.

The sections that follow discuss the findings in relation to the research questions and the wider evidence on remediation in the context of FtP.

4.2 How do regulators in health and selected non-health sectors operate, manage and evaluate their approaches to remediation, how does this compare to the GDC's approach, and what learning is there for the GDC?

Regulators in various sectors, both health- and non-health related, employ a range of strategies to manage and evaluate remediation. The approaches often reflect the specific regulatory contexts and legislative frameworks governing each sector. For instance, health regulators frequently adapt their remediation strategies based on evolving case law, public confidence concerns and conversations with registrants.

In the health sector, some regulators have developed remediation frameworks aimed at addressing professional deficiencies early. For example, the NMC and the GMC have implemented structured remediation programmes that focus on CPD and targeted interventions. These programmes are designed to address behavioural issues and skills deficiencies before they escalate to become more serious FtP issues.

In non-health sectors, regulators like the Financial Conduct Authority (FCA) have also integrated remediation into their oversight processes. These sectors appear to emphasise compliance and corrective actions over punitive measures, recognising that early intervention can prevent more serious breaches. For instance, the FCA's approach includes a combination of training, mentoring, and monitoring to ensure that individuals and firms rectify issues promptly.

The GDC's current approach to remediation appears less structured compared to these other regulators. While there is recognition of the benefits of early remediation, its application within the GDC is inconsistent, and there are disparate thoughts on how it could be implemented in the future.

4.3 The current state of the GDC's approach to remediation

4.3.1 What is working well?

There is a broad consensus among GDC staff and stakeholders about the potential benefits of early remediation. When effectively implemented, remediation can:

- Improve professional standards.
- Address concerns about clinical performance.
- Prevent the escalation of professional conduct issues.
- Maintain public confidence in the dental profession.

GDC staff have shown a willingness to incorporate remediation early in the FtP process, and we found that early remediation was generally felt to be the right direction of travel for the GDC. This openness indicates a positive attitude towards developmental approaches rather than punitive measures.

4.3.2 Challenges and barriers to effective remediation

Conceptualising remediation

One of the primary challenges facing the GDC is the inconsistent application of remediation across different cases. This inconsistency is often due to a lack of clear guidelines and, consequently, a varied understanding among decision-makers about what constitutes effective remediation. This was particularly apparent in the discussion of the extent to which reflective practice could be deemed to be, on one hand, a genuine display of insight, prognostic of no ongoing concerns, or on the other, an insincere performative exercise intended merely to 'tick a box.'

The concept of remediation was a multivocal one – in other words, it 'spoke' to different people differently, hence the understanding of it was heterogeneous across stakeholders and inconsistent within organisations. At times there was confusion between remediation as an approach to mitigating attitudinal or behavioural risk, versus remedial clinical actions undertaken to repair harm done to patients. Some participants saw remediation as a loaded, even dangerous term, and a varied lexicon had been developed across stakeholders to describe the concept. These included 'strengthening practice,' 'risk mitigation' and 'CPD,' as well as 'conditions,' 'undertakings' and 'sanctions,' which were often framed as enforced or punitive remediation.

Consequently, there is a need to disambiguate the language of remediation and clarify the extent to which it overlaps with, or is distinctive from, other currently-used terms in the sphere of professional development and professional learning. It also appeared that the framing of remediation as an early, developmental response to FtP concerns may be in tension with established ideas of punitive or 'enforced' remediation, and so clear messaging is needed around this. As Price et al. report there is no magic-bullet for remediation, and the field needs to explicitly recognise the complexity of remediation (Price, 2021).

> "It is easy to see, after all, how remediation (or the threat thereof) could become inappropriately coercive and controlling. Whenever a judgment is made, both judge and judged must be prepared to come under scrutiny. While the use of remediation for coercive purposes is clearly problematic, the health professions cannot be so individualistic as to have no structure at all. We need to be able to guide learners and assess when they are failing or succeeding, while also allowing for their individual circumstances and trajectories." (Ellaway, 2023)

The role of reflection

The nature and role of reflection, and the relationship between reflection, remorse, mitigation and remediation were ambiguous, contested concepts within the data. Some participants saw reflection as something other than remediation – a categorically different activity, to the extent that they could exist independently of each other. These participants held that registrants could undertake remediation (for example in the form of relevant CPD activities) without undertaking reflection, which they linked to deeper understanding and insight. Others saw reflection as being at the heart of remediation – for them, remediation without reflection wasn't really remediation at all, thus the two were inextricably linked.

At the heart of all of these notions was an expectation that reflection should be genuine, with participants suggesting different approaches to the verifiability of its authenticity. For some, it was about connecting any claimed insights to demonstrable change in practice, and so reflection alone was insufficient to demonstrate a change in practice. For others, it was about hearing from registrants 'in their own words' - for these participants, there was something about the enactment of contrition that they found compelling. Theoretically, therefore, reflection alone might represent sufficient evidence of remediation, aside from any evidence of behaviour change – for these participants, evidence of regret and insight was the primary concern.

Others were sceptical of reflections that, in their view, amounted to mere expressions of remorse after the fact. There was a concern that these expressions may be insincere, only being expressed because the person had been 'caught,' and there was particular scepticism if the original behaviours had been especially egregious. The timing of expressions of remorse was also felt to be relevant – if a participant were to dispute the facts of a case, only to express remorse when the facts were subsequently proven, then their remorse would be deemed to count for very little.

There was a distinction to be made, in the minds of some participants, between the role of reflection in remediation versus risk mitigation, wherein reflection might constitute mitigation, but not remediation. This was complex to disentangle, as participants had often turned to the concept of risk mitigation in their definition of remediation – for many the purpose of remediation was, at least in part, to provide assurances that any ongoing risk had been ameliorated. The case in point was sexual misconduct, wherein it was felt that remediation might be difficult to demonstrate, but sincere reflection and insight might provide assurance that a registrant had understood the impact of their actions and undertaken to behave differently in the future.

Our findings marry those within the broader health professions literature that insight is important for successful remediation (Price, 2021; Prescott-Clements, 2017; Wu, 2010).

Operationalising remediation

The adoption of early remediation as a mechanism for the early closure of cases was felt to be a policy decision within the current purview of the GDC, rather than something that would require a change to current legislation. It remains to be seen how it might be implemented operationally. Research participants frequently referred to the highly contextual and contingent nature of alleged professionalism breaches, and there was a feeling that those involved in the initial assessment or at the case examiner stage would need clear guidance on what effective remediation should look like. These two ideas may, in fact, be difficult to reconcile - judgement-based decisions are not easily reduced to clear guidance or protocols. Other regulators noted that context was considered but there were no formal guides or proformas.

At present, there is a feeling that there are inequities in the way the FtP system functions, with differential access to legal advice and representation having an unfair impact on registrants who, for whatever reason, have not had the benefit of appropriate guidance. It is likely, therefore, that changes to the way in which remediation is viewed and considered by the GDC will further marginalise these registrants, unless steps are taken to ensure that the remediation system functions fairly.

Over and above awareness, there was also the view that some registrants have differential opportunities to remediate, as certain remedial and professional development practices (e.g. supervision, mentoring, peer review) are more challenging when working as a locum or for an agency. It could be argued that a 'lighter touch' early remediation framework might reduce differential experience for some staff groups (international, locum etc). EDI issues are worthy of further research too.

Lack of trust

Some of the actions of the GDC were seen to have eroded trust amongst registrants, such that registrants may be unwilling to engage with the regulator positively and constructively at an early point in FtP proceedings.

Health professions regulators, including the GDC, were perceived to escalate cases in order to bring maximal charges against the registrant, for example by weaponising the notion of dishonesty to add layers to cases. This has the effect of introducing alleged facts into a case that the registrant may wish to dispute, rather than address through remediation. It also frames the regulator as a bad-faith actor with whom sincere engagement is impossible or unwise.

Other more public manifestations of the GDC's perceived modus operandi have had a similar negative impact on trust. The use of undercover investigators to pursue beauticians and GDC registrants believed to be involved in breaches of the law and professional standards, has eroded trust (GDC, 2019; BDJ In Practice, 2019). Perceptions of the GDC's response to certain legal proceedings, including perceptions that they gave illegal advice to panels to ignore a High Court judgement and that a response to a high-profile Prevention of Future Deaths report lacked empathy, have compounded the problem.

Other important issues included the fact that the current FtP process is often perceived as adversarial, which can hinder the effective implementation of remediation. An adversarial approach may frame remediation as punitive rather than developmental, deterring dental professionals from engaging positively with the process.

Lengthy investigations of relatively minor cases have also been acknowledged to cause frustration and compromise trust (GDC, 2023). However, recent findings from the 'Initial inquiries pilot' suggest that registrants have largely trusted the GDC sufficiently to engage with a new initiative aimed at closing appropriate cases early (GDC, 2024), which bodes well for similar projects that rely on early engagement and candour.

4.4 Future aspirations

4.4.1 What might 'better' look like?

The GDC aspires to create a more consistent and supportive approach to remediation within its FtP process, with a particular interest in remediation as a pathway to the early closure of appropriate cases.

This vision includes making early remediation a standard consideration, and the GDC could support this through a number of different steps and approaches.

A better approach may involve structured frameworks for remediation, similar to those used by other regulators, such as the NMC. These frameworks could include specific criteria for identifying deficiencies, targeted interventions, and ongoing monitoring to ensure compliance and improvement. Ideally, they would be shared with key stakeholders, including decision-makers at all points in the FtP process and the registrants themselves, in order to avoid a 'hidden curriculum' in regard to acceptable remediation. This might go some way to addressing the current perceived inequity in the system, where people's chances of avoiding a finding of impairment are felt to be correlated with their access to legal representation and advice.

The development and implementation of clear policies and guidelines are important. These should provide decision-makers with detailed instructions on how to apply remediation measures effectively and consistently. Comprehensive training programmes for decision-makers would also be important. These programmes should cover the principles and practices of effective remediation, enabling decision-makers to apply these measures confidently, appropriately and consistently.

A continued shift towards a more supportive and developmental regulatory culture is also essential. This involves recognising and embracing remediation as a tool for professional development rather than solely as a punitive measure.

4.4.2 The journey to 'better'

Clarifying the concept of remediation

The first step in the journey to better remediation is clarifying the concept itself. This involves developing a common understanding and language around remediation amongst all stakeholders. GDC decision-makers and registrants should be supported to develop a shared mental model of what is meant by remediation, including how it is similar to, overlapping with or different from existing processes of professional learning and development, and how it can be integrated with the FtP process in supportive and productive ways that go beyond box-ticking and deliver genuine improvement, risk mitigation and public confidence.

Policy and legislative adjustments

There was a general sense that sufficient accommodation might be made through internal policy adjustments. However, there may also be a need for legislative changes to fully integrate remediation into the FtP process. The much-vaunted regulatory legislative change may yet be some way off, but this may create the opportunity for the GDC to build calls for any remediation-related changes into their ongoing advocacy work, highlighting the benefits of early remediation e.g. for operational efficiency, registrant wellbeing and public safety.

Developing comprehensive training programmes

Comprehensive training programmes for decision-makers are essential. These programmes should include practical training on identifying deficiencies, applying remediation measures, and monitoring progress. Training should also focus on fostering a supportive and developmental mindset among decision-makers.

Implementing clear guidelines

The GDC may wish to follow the approach of other regulators in developing and implementing clear guidelines for remediation. These guidelines should provide detailed instructions on the application of remediation measures, including specific criteria for identifying deficiencies, appropriate interventions, and monitoring procedures.

Promoting a cultural shift

Achieving a cultural shift within the GDC involves promoting the value of remediation as a developmental tool. This shift requires ongoing communication and engagement with stakeholders, emphasising the benefits of a supportive and developmental approach to regulation.

Registrants and their representatives, including lawyers who may be from criminal defence backgrounds, need to be helped to understand that the GDC is attempting to move to a more supportive, upstream model of regulation, and the GDC needs to demonstrate that with clear actions aimed at fostering trust. In doing so, the old adage that "trust arrives on foot and leaves on horseback" is salient – high-profile examples of the GDC appearing to escalate cases, catch registrants out through undercover investigations and ignore High Court rulings quickly erode trust that, in many smaller and more consistent ways, may have been slowly accreted.

4.5 Strengths and limitations

The strengths of this research lie in a number of features of the work, including:

- Engagement with, and comparative analysis across, a range of stakeholders
    - GDC staff
    - healthcare and non-healthcare regulators
    - Legal representatives;
- In-depth qualitative methodology, which surfaced detailed and complex issues around the concept and practice of remediation;
- Regular discussions between members of the research team about emerging themes in the data.

As qualitative research, the project was designed to generate idiographic data to understand the complex anatomy of the issues that are at hand when considering the role of remediation in FtP. This is a strength of the research, however it is appropriate to acknowledge that the findings are not demonstrably generalisable using this methodology. That said, while there were inevitable contradictions and variations within the data, there were also regularities that supported strong conclusions being drawn.

4.6 Further research

While there is no inherent tension between the regulatory goals of ensuring patient safety and maintaining public confidence in the profession, the issue of remediation reveals instances when these goals may be not be readily rationalised; there are occasions on which, for example, breaches of the professional code may have been so egregious that, despite the limited chance of repetition, public confidence may be deemed to be threatened by allowing a registrant to continue to practise.

We are interested, therefore, in the extent to which the public attitude to various professionalism breaches reflects the assumptions of the regulator, and to what extent the public may in fact take a more or less charitable view of what is and is not remediable. Further research into the public attitude to remediation would further inform the GDC's ongoing work in this regard.

Figure 2 provides a visual summary of the key considerations and evidence that are required in order to operationalise and support the adoption of early remediation at the GDC.

Table 2: Evidence and considerations required for operationalising and supporting remediation at the GDC

EVIDENCE	CONSIDERATIONS
Caution should be taken when accepting routine CPD as evidence	Registrants must trust the regulator
Reflection is useful for demonstrating insight and meaningful learning. Remediation needs to move beyond expressions of remorse.	Context must be taken into account.
Pay attention to proximity of remediation to hearing (time needed to embed learning; risk of performative CPD/box-ticking)	Representation can assist – ensure support for those without representation.
Courses need to be relevant to the issue being remediated.	There must be a willingness to consider evidence of remediation earlier.
Timelines, duration, and accreditation of courses need consideration. Proximity to hearings is important – changes in practice, skills and behaviours need time to embed.	A risk positive approach must be adopted.
Public trust may outweigh any evidence of remediation when making decisions.	Processes must focus on the developmental, not the punitive.
Testimonials should be from colleagues with supervisory roles or relevant to the charge.	Equity of opportunity to remediate must be considered e.g. locums, part-time, international registrants etc.

4.7 Conclusions

The evidence in this research suggests that remediation is the right direction of travel for the GDC. The rationale for this was that the process would be:

- Time efficient.
- Fair to all parties.
- In alignment with other regulators.
- Would instil greater confidence in the GDC from the perspective of registrants.
- Would enable only the most serious cases to go forwards to full hearings.

Remediation can often be described as 'course-correction', suggesting that there is one way to do things, a set of golden rules, or one way of being a professional (Ellaway, 2023). In reality, the form that remediation takes is likely to be context-dependent, but it should be framed as positive and developmental, in the spirit of supportive, humanistic regulatory practice, rather than punitive. An ethical approach would also require the process to be equitable, taking account of variations in: the level of awareness of FtP; access to trusted, personalised advice; and resources and opportunities needed to enact remediation, within and across professional groups.

Implementation will be challenging, requiring conceptual clarity, clear policy and guidance, appropriate training for key decision-makers, and a change in culture across all stakeholders, including the GDC, the PSA, registrants and their legal representatives. Developing and maintaining trust is a key element of this, and we have referred earlier in the report to examples of actions that have caused trust to accrue or be eroded in the past.

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Appendix 1. Documents sourced for thematic analysis

Organisation	Document	Observations
General Medical Council (GMC)	Fitness to practise Guidance for decision makers on agreeing, varying and revoking undertakings Handbook for performance assessors Test of FtP at the point of registration	The GMC is responsible for maintaining the official register of medical practitioners within the UK. It ensures that doctors adhere to the standards of good medical practice, which includes competence, ethical behaviour, and the ability to communicate effectively with patients. The GMC's FtP process involves: • Initial Assessment: Complaints are assessed to determine if they fall within the GMC's remit. • Investigation: Detailed investigations include gathering evidence, interviewing witnesses, and obtaining expert opinions. • Interim Orders Tribunal: In cases where there is a significant risk to public safety, the doctor may be suspended or have conditions imposed on their practice while the investigation continues. • Fitness to Practise Panel: A formal hearing where the evidence is reviewed, and decisions are made regarding the doctor's fitness to practise. Possible outcomes of GMC investigations include: (i) No further action; (ii) Warnings; (iii) Conditions or restrictions on practice; (iv) Suspension; (v) Erasure from the medical register. A key aspect of remediation involves the doctor's ability to reflect on their actions and demonstrate insight. This includes recognising and acknowledging what went wrong; understanding the impact of their actions on patients and the public; and demonstrating a commitment to learning from these experiences. Doctors are expected to take concrete steps to address any identified deficiencies. Remediation actions can include undertaking additional training or education to improve skills; participating in supervised practice to ensure safe performance; and engaging in professional support services such as counselling or mentoring. As part of the FtP process, doctors must provide evidence of their remediation efforts. This may include reflective statements detailing what they have learned and the changes they have made;

Organisation	Document	Observations
		certificates of completed training or educational programmes; and reports from supervisors or mentors confirming improvements in practice. Remediation is emphasised as helping doctors improve their practice and prevent future issues; supporting the rehabilitation of doctors while ensuring public safety; and demonstrating a doctor's commitment to maintaining high professional standards.
Nursing and Midwifery Council (NMC)	Fitness to practise Insight and Strengthened Practice	The NMC regulates nurses, midwives, and nursing associates in the UK. It sets standards for education, training, conduct, and performance, ensuring that professionals provide high-quality care throughout their careers. The NMC's FtP process includes: • screening: Initial screening of complaints to determine if they fall within the NMC's jurisdiction. • investigation: Collecting evidence, interviewing the registrant and witnesses, and reviewing medical records. • case examiners: Assessing whether there is a case to answer and if the matter should proceed to a formal hearing. • Fitness to Practise Committee: Conducting hearings to determine the registrant's fitness to practise. Key Considerations: The NMC considers several factors during FtP investigations, including the registrant's insight into their actions; remedial actions taken to address the issues; and the risk of harm to the public if the registrant continues to practice. The NMC emphasises the importance of reflection and learning from mistakes. Remediation actions may include further training, supervised practice, and engaging with professional support services.

Organisation	Document	Observations
Health and Care Professions Council (HCPC)	HCPTS Practice Notes Sanctions Policy	The Health and Care Professions Tribunal Service (HCPTS) is an independent body that adjudicates FtP cases for health and care professionals regulated by the HCPC. The HCPTS ensures that decisions regarding a professional's fitness to practise are made impartially and independently from the HCPC's investigation processes. HCPC FtP Process: *Initial Screening and Investigation*: Concerns about a registrant's fitness to practise are initially investigated by the HCPC. This involves gathering evidence, interviewing witnesses, and assessing whether there is a case to answer. If it is determined that the case should proceed, it is referred to the HCPTS for adjudication. *Hearings:* The HCPTS conducts hearings where evidence is presented, and witnesses may be called to testify. Hearings can be public or private, depending on the nature of the case. The panels at these hearings include registrant and lay members to ensure diverse perspectives in decision-making. *Adjudication and Outcomes*: The panel at the HCPTS hearing determines whether the registrant's FtP is impaired. Outcomes can range from no further action to conditions of practice orders, suspensions, or even removal from the professional register. The panel's decisions are based on protecting public safety and maintaining professional standards. With regard to the remediation process, as with the GMC, registrants are encouraged to reflect on their actions and demonstrate insight into their professional shortcomings. This involves acknowledging what went wrong, understanding the impact on patients and the public, and learning from the experiences. Demonstrating genuine insight is presented as critical as it shows the ability to improve and prevent future issues. As with other regulators, steps to remediate practice include undertaking further training or education to address specific areas of deficiency; engaging in supervised practice to demonstrate

Organisation	Document	Observations
		improved competence; participating in professional development activities; seeking professional support, such as counselling, if personal issues contributed to the misconduct. These actions are aimed at ensuring that the professional can return to safe and effective practice. Throughout the FtP process, professionals are expected to provide evidence of their remediation efforts. This can include reflective statements, certificates of completed training, or reports from supervisors. The HCPTS panels consider these efforts when deciding on the appropriate outcome for the case. The goal of the FtP process is not only to protect the public but also to support the rehabilitation of healthcare professionals where possible. Effective remediation helps professionals improve their practice, regain their confidence, and continue to contribute positively to the healthcare system. By focusing on both accountability and improvement, the HCPTS specifies its aims to uphold high standards while enabling professionals to learn and grow from their experiences.
Committee of Postgraduate Dental Deans and Directors (COPDEND) (2015)	Remediation of Dental Registrants in Difficulty	Provides detailed guidance notes on the management of remediation cases referred to Dental Postgraduate Organisations. Specifies that ultimate responsibility for remediation rests with the registrant. The role of the Postgraduate Dental Deans and Directors, and their staff, is stated as to provide assistance in constructing a remediation action plan, to give advice on resources available to the registrant, to monitor the milestones in the action plan and to transparently report back to the regulatory body, if required. Since 2021, dental professionals working in England have been responsible for selecting their own development adviser to support with conditions and undertakings, subject to minimum requirements and final approval from the GDC.