MPS’s response to the consultation on statutory multi-agency guidance on Female Genital Mutilation

Overview

Medical Protection Society (MPS) welcomes this opportunity to respond to the consultation on the draft statutory multi-agency guidance on Female Genital Mutilation (FGM).

In January 2015 MPS responded to the Home Office consultation on proposals to introduce mandatory reporting of FGM. While not taking a view on the merits or otherwise of the proposals for the new duty, in this response, we stated that the legislation and the statutory guidance for the implementation of the reporting duty must be flexible enough to ensure that individual, and sometimes quite complex, circumstances of a case are taken into account. A balance has to be achieved between any duty to report and ensuring patients are not deterred from seeking medical advice or withdrawing from it. We have some concerns that this draft guidance, in relation to the mandatory reporting duty for healthcare professionals, lacks the necessary flexibility.

In many circumstances a notification period of one month will be sufficient for the doctor to be satisfied that the necessary safeguarding measures are in the place and that the necessary trust required in the doctor-patient relationship has been established. However, in other circumstances this may not be the case. The doctor, acting in the best interests of the patient, may feel that a number of months and appointments are necessary to ensure the safety of the patient, to mitigate risk and to establish trust. Reporting the FGM in that time period may not in the best interests of the patient. Clearly, where the patient or other young people are at immediate risk, the doctor will take the necessary urgent steps.

The ‘expectation’ set out in this draft guidance that most cases are reported within 24 hours, may pose difficulties. Unless the situation is an emergency, doctors may want to be satisfied that appropriate safeguarding measures are in place, and this may take more than 24 hours.

We recommend that the ‘expectation’ of a 24 hour reporting period is removed, or lengthened, and that greater flexibility is built into the notification period requirements to allow doctors to make decisions that are in the best interests of their patient.

MPS would have preferred to see this guidance published well in advance of the commencement of the mandatory reporting duty as it is important to ensure that they are well prepared for legislative change before it occurs.
Finally, MPS would like to recommend that that guidance is reviewed in a years’ time to ensure that it remains useful and appropriate.

As a membership organisation representing doctors, dentists and healthcare professionals, MPS is only responding with regards to healthcare professionals.

**Specific Responses**

**Mental capacity**

The statutory guidance does not make reference to the legal framework around mental capacity or competent children. Doctors will have to make a judgement call on how involved a child can be in the discussions around FGM and its reporting. When considering under 18’s, who are adolescents, it should be recognised that there is a fine line between safeguarding the child and placing her in a difficult position with regards to any potential repercussions with her parents.

**Chapter 4.1:** The doctor’s priority is the health and wellbeing of their patient (Chapter 8.2) and the doctor may need time to build a (stronger) relationship with the patient.

The ‘expectation’ set out in this draft guidance that most cases are reported within 24 hours, may pose difficulties. Unless the situation is an emergency, doctors may want to be satisfied that appropriate safeguarding measures are in place, and this may take more than 24 hours. Failure to report within this initial time period should not be met with condemnation towards the health care professional.

We recommend that the expectation of a 24 hour reporting period is removed, or lengthened, and that greater flexibility is built into the notification period requirements to allow doctors to make decisions that are in the best interests of their patient. Clearly, where the patient or other young people are at immediate risk, the doctor will take the necessary urgent steps.

**Chapter 4.1.1; 4.1.2 and Chapter 4.2.2:** It may be the case that reporting an incidence of FGM could put the patient or any other siblings at (further) risk if action to mitigate this is not taken prior to reporting. In many cases the one month period can give allowance for this to happen. However, if the doctor believes that the risk to the patient or any other siblings still exists they should not be required to report until appropriate safeguarding measures are in place. The statutory guidance should be flexible enough to allow for this.

**Chapter 4.1.2:** The draft guidance does not specify in what circumstances it would be most appropriate to share concerns of an ‘at risk’ girl with the police, or with social care. MPS believes that the guidance should be more explicit and state that social care should be the first preference, unless in an emergency and then it would be the police. The choice provided to practitioners in the guidance as to whom they should raise concerns, could create confusion.

**Chapter 4.2.1:** The guidance does not provide advice on how doctors should raise the discussion of FGM to ensure that families know it is illegal. Doctors need to approach this issue with sensitivity and the doctor cannot lose the trust of their patient by mismanaging the situation. In order to be able to appropriately broach the subject with patients, doctors may be well served by an information ‘how to’ leaflet.
Chapter 4.3: The guidance does not provide clarity on how a healthcare professional should manage the situation if a patient with FGM is registered at an all-male GP practice. It needs to be clear what would be considered an adequate substitute to ensure a female professional was available. For example, it may be that a female nurse would be sufficient.

Chapter 4.3; An accredited female interpreter: The guidance states that "an accredited female interpreter may be required." The practicalities of this advice do not appear to have been considered. Firstly, the healthcare professional cannot predict who will need an interpreter before the consultation. It may be very difficult to find ‘an accredited female interpreter’, who is "appropriately trained in relation to FGM," speaks the same language as the girl, but is not known or influential in the community – or even from the community. Further, any interpreter would need to be fully conversant – and in agreement – with the law. The doctor, not likely knowing the interpreter, may have reservations as to what is being translated to the patient.

One suggestion may be to make arrangements for the patients to attend a further appointment, when an interpreter can be present. However this may create further concerns if there is a risk that the girl may be exposed to further risks as a result. Such a solution may also be in contravention of the expectation outlined in this guidance that a doctor should report a suspected case within 24 hours.

Unless there exists an up-to-date database, in which the healthcare professional can find an interpreter who meets the criteria set above, it will be extremely difficult to find one who the doctor could be fully trusting of, and in a sensible timeframe.

Questions

1. Do you agree that the draft statutory guidance provides frontline professionals with the information they need on the prevalence of FGM and the issues around it? If not, where and how could the guidance be changed?

MPS agrees that, on the whole, the draft statutory guidance provides frontline health care professionals with the information they need. The guidance should be kept as simple as possible and should allow doctors to absorb the necessary information quickly. To this end, MPS recommends the creation of a single-page overview outlining the procedures healthcare professionals should follow.

However, MPS is concerned that this guidance is not flexible enough to ensure that individual, and sometimes quite complex, circumstances of a case can be taken into account.

2. Do you agree that the draft statutory guidance provides service delivery organisations with the information they need on the prevalence of FGM and the issues around it? If not, where and how could the guidance be changed?

Not applicable

3. Do you agree that the draft statutory guidance adequately captures FGM risk factors?
MPS agrees that the draft statutory guidance adequately captures FGM risk factors. In order to assist doctors, we would welcome a simple flowchart which doctors could use when understanding the risk factors, and what steps need to be taken depending on the risk.

4. Do you agree that the draft statutory guidance captures the full range of legal tools and interventions to enable professionals and public sector organisations to safeguard and protect women and girls at risk of FGM?

Not applicable

5. Do you agree that the draft statutory guidance promotes an individual-centred approach, ensuring that a woman or girl’s individual circumstances drive the decision making process at all times? If not, what additions do you consider could be made to the guidance?

MPS agrees that a woman or girl’s individual circumstances should drive the decision making process. The statutory guidance must be flexible enough to ensure that individual, and sometimes quite complex, circumstances of a case can be taken into account. We are concerned that this draft guidance lacks the necessary flexibility.

In many circumstances a notification period of one month will be sufficient for the doctor to be satisfied that the necessary safeguarding measures are in the place and that the necessary trust required in the doctor-patient relationship has been established. However, in other circumstances this may not be the case. The doctor, acting in the best interests of the patient, may feel that a number of months and appointments are necessary to ensure the safety of the patient and to establish trust. Reporting the FGM in that time period may not in the best interests of the patient. Clearly, where the patient or other young people are at immediate risk, the doctor will take the necessary urgent steps.

The expectation set out in this draft guidance that most cases are reported within 24 hours, may pose difficulties. Unless the situation is an emergency, many doctors may want to be satisfied that appropriate safeguarding measures are in place, and this may take more than 24 hours.

We recommend that the expectation of a 24 hour reporting period is removed, or lengthened, and that greater flexibility is built into the notification period requirements to allow doctors to make decisions that are in the best interests of their patient.

6. Do you agree that the draft statutory guidance provides sufficient - and clear information for a) health care providers b) police c) children’s social care and d) schools and colleges?

MPS makes no comment with regards to the information provided named above except for healthcare providers.

MPS agrees that, on the whole, the draft statutory guidance provides frontline healthcare professionals with the information they need.

However, MPS is concerned that this guidance is not flexible enough to ensure that individual, and sometimes quite complex, circumstances of a case are taken into account.
7. Do you agree that the draft statutory guidance captures how professionals and public sector organisations can work with communities to prevent FGM?

Not applicable

8. Do you agree that the draft statutory guidance describes a multi-disciplinary approach which will allow for the voice of the child to be heard and respected whilst working to protect and support her? If not, where and how could it be improved?

Not applicable
About MPS

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

CONTACT

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