6. **Revalidation – evidence and quality assurance**

**MR STEPHEN BREARLEY:** As is usual when presenting papers like this, I would like to give thanks to all of those who have put effort into it. The number of people and the amount of effort on this occasion are greater than the average, and I am particularly grateful to everybody who has helped and contributed.

The paper deals with two aspects of the revalidation project, namely the evidence that we shall expect doctors to submit and then the question of how we quality-assure not only the evidence but the whole process.

The paper starts off with a background section of about nine paragraphs which I think is very important and I will spend a few moments talking about it, if you will allow me. The purpose of this section is to help us all to clarify in our own minds where revalidation fits into the overall picture of regulation in healthcare. I think that we are becoming increasingly aware that this is a jigsaw puzzle with many pieces to it, fitting together to make a complete picture, and we have to keep reminding ourselves of that.

Paragraph 4 points out that the GMC has a unique role in this, but the overall task is shared with other very important players – our partners. Paragraph 5 summarises the aims. Dealing with dangerous and dysfunctional practice is one of them. Numerically, of course, it will be very much more the case that we are simply ensuring that doctors are indeed up to date and fit to practise. We should not forget the aspect of steady improvement in standards of medical practice, which has always been part of the aim of this exercise.

Paragraph 6 indicates some of the other pieces of the jigsaw. It mentions in particular clinical governance. I was not completely clear from the talk we had from Aidan Halligan this morning. It was presented very much as a sort of facilitative, developmental thing, but it clearly also has regulatory and controlling aspects to it as well – including, where necessary, suspending doctors who are seen to be dangerous. It is all part of clinical governance. Then there is guidance from the royal colleges; there is audit and inspection by CHAI; there is support provided through NCAA.

The paragraph on which I would like you to concentrate – and which I hope you have thought about since you, rather belatedly I am afraid, received this paper – is paragraph 7. The analysis in this paragraph seeks to categorise the sorts of doctors that we might meet in the overall picture of regulation in healthcare. It starts off with those who may be an immediate danger to
patients. There are not very many of them but there are a few, and they are clearly a group which has to be dealt with promptly and effectively.

Then (b) is a group who are showing evidence of emerging dysfunction, where it appears that the problem can be dealt with and rectified locally; but, if that does not prove possible, then action at GMC level may be necessary.

Then there is a group where there are doubts about the doctor – not sure whether this doctor is fit to practise or not. There is the large group, we believe the vast majority, (d), where there are not any doubts, and we think that the doctor is fine.

Over the page there is what I believe to be a truly exceptional category of doctor, but it is the group into which Dr Shipman fell – those who are undertaking or perpetrating deliberate criminal harm to patients.

Which tools, which of the processes set out in paragraph 6, will be involved in dealing with each of these different stages? Where a doctor is an immediate danger to a patient, it is clearly necessary for those employing the doctor or contracting with the doctor at local level to take immediate action to protect patients from him or her. This is not something which a revalidation cycle, completed over the course of five years, is quick enough off the blocks to deal with. It may very occasionally be that people will get to the revalidation point and the fact that they are an immediate danger to patients has not been picked up: in which case, revalidation may have a role. Generally speaking, however, this is the sort of problem that will be dealt with very much faster than that locally.

The same applies to doctors who are showing evidence of emerging dysfunction. We have always said that revalidation is a rolling process; but, as far as the GMC is concerned, it is a process which happens once every five years. The other bits of it are a local process. Emerging dysfunction will need to be picked up and hopefully dealt with locally but, if it cannot be, it will need to come to us.

Where revalidation really has its strength and its major contribution to make surely concerns categories (c) and (d). Regarding category (e), once again I would say that the fact that we will have revalidation probably “safety-nets” the situation as far as deliberate criminal harm to patients is concerned. One would hope the fact that it exists means that a doctor like Shipman would be more likely to be picked up. Clearly, criminal harm to patients is essentially a police matter. It depends upon looking at evidence about doctors’ practices at local level, and taking firm action at local level immediately it becomes apparent that the doctor concerned is prescribing vast quantities of morphine or having extraordinary numbers of patients dying in his surgery. I hope that is helpful in putting revalidation into the context of all the other parts of the picture.

Paragraph 12 enunciates a principle, and I think that it is worth pausing over this as well. In order to satisfy us that they remain up to date and fit to
practise, doctors will have to provide us with evidence. We produced a prospectus in April which set out two alternative routes to revalidation, but underpinning it all is the principle that the type of evidence we are looking for is the same, irrespective of what route the doctor is taking to have it submitted and certified. We do not expect the evidence to be different in kind. It is purely a question of the way the evidence is put together, handled, submitted and evaluated.

Those are a few background points that I wanted people to be clear about before we move on. We then get into the discussion section. Again, we are setting out some principles here which I hope will be entirely self-evident and readily accepted.

First of all, we agreed some time ago that it is self-evidently the case that the evidence which is submitted must be capable of verification. There are various ways in which we would expect to verify it. We can of course be involved in sampling evidence for a proportion of doctors as part of our quality control processes.

The second principle, 14(b), is that all doctors participating in revalidation will be required, amongst other things, to provide us with a description of the practice they have undertaken during the revalidation cycle. This has been an established principle from way back in the exercise, and the purpose is to enable us to judge whether the evidence which the doctor has provided us is actually appropriate and sufficient, given the context of practice.

Then (c) again is a long-established principle, that the evidence must cover all the principles in Good Medical Practice where these are applicable to a doctor’s own practice.

Then (d) is a new one – or new expressed in these terms. We have always recognised that there would be freedom for doctors to choose what sort of evidence they submit to us. What we intend to do, however, is to produce a list of acceptable types of evidence from which we would normally expect doctors to choose. There will be flexibility, and the aim with this list would be that there will be types of evidence on it from which doctors in any field of practice could choose, in order to meet the requirements of revalidation. The other thing that the Registration Committee are quite clear about is that there should not be any soft options on here. All of these alternatives need to be of equivalent rigour and equally reliable.

That leads us to the first recommendation in the paper, which simply invites you to endorse the four principles set out above. I hope that is not controversial and that people will be happy to accept that.

**THE PRESIDENT:** Are we content? [Several members: Yes]
PROFESSOR CHRISTOPHER BULSTRODE: Could I make some points about this paper, because I think that it is an important one?

First, section 4. As Stephen pointed out, there will be a large number of organisations involved in this process. I would very much like to see the GMC take a lead in bringing these organisations to work in harmony with each other, rather than as a turf war. I would like to see that the whole is more than the sum of the parts, rather than petty squabbling. Working together, we can be very powerful indeed. Working against each other, we could get into a terrible tangle.

THE PRESIDENT: I very much agree with that. Do you want to speak to that, Peter?

PROFESSOR PETER HUTTON: The issue of revalidation has been around for a couple of years, and the views that various organisations and various individuals have taken have waxed and waned over the relevance of bodies outside the GMC to be of help.

Speaking generically from the point of view of the colleges, whenever it has been discussed there has never been a dissenting voice that the colleges should not be involved in revalidation, appraisal and in CPD.

Trying to paint a picture in a thumbnail sketch of what has been discussed, it is whether or not the objective of revalidation should be to confirm that the majority of doctors are performing adequately or whether it should be to detect the small proportion who are not. There is a discussion to be had about the tools that one uses for those two procedures – which are probably different. As a profession, we perhaps have not quite teased that out. The excellent paper which Stephen has produced is essentially suggesting that both those things should be done.

THE PRESIDENT: Picking up Chris’s point that we all need to work together on this, at the present time we are working together on this.

PROFESSOR PETER HUTTON: I was going on to say that all of those things have been discussed, but there has never ever been dissent that we should not collaborate over it.
**THE PRESIDENT:** Do you want to come back on that, Chris, because it is quite an important point?

**PROFESSOR CHRISTOPHER BULSTRODE:** Could I go on to another point? This revalidation issue is to do with the threshold of whether somebody is competent to practise or not. As soon as you start to talk about thresholds, you have to talk about criteria; you have to validate your criteria; but you also have to set the threshold at which that criteria will work. I can find nowhere in this document where we start talking about that. I understand why, but I do not think that we can leave that to local forces to decide. I think that we may need to take a lead once again in giving guidance as to how we might, in the future, think about setting those thresholds and even changing those thresholds. As this process becomes more culturally acceptable, we may be able to move those thresholds up to where we want them to be.

**PROFESSOR JAMES DRIFE:** Another small but general point on what I thought was an excellent paper. In paragraph 7 on page 2, I really felt quite uneasy at the order of paragraphs there – in a paper that is on revalidation – where the majority of doctors are tucked away in subparagraph (d) and the “clear and present danger to patients” is the first thing that strikes your eye.

I realise what is going on at the moment but, if this is going to be referred to – as it certainly would be referred to me when we are next talking to a group about revalidation or if it goes on the website – if the first thing you see is “clear and present danger to patients”, I think that it sends all the wrong messages to everybody.

**PROFESSOR ROBERT SHAW:** Coming back to Chris’s point, at the level of expectations of the practitioner, surely this is different to the performance procedures where you are dealing with registration as a whole – as to whether they can be on the register? Here it is to identify and confirm that they can perform the posts that they have been doing in the last few years and are doing currently. It will be across a whole spectrum of different levels, depending on their level of training, the position, and what they are doing within that post. It is very much individually based, therefore, and not quite so generic as issues with performance procedures and registration as a whole.

**THE PRESIDENT:** Do you want to pick up these points, Stephen, before we move on?
MR STEPHEN BREARLEY: I think that the outstanding one concerns the question of thresholds, guidance, and so on. The paper did not set out to deal specifically with that. Members will recall very well that the policy has long been that doctors who were suspected of not being up to date and fit to practise would face the possibility of referral to the Council’s fitness to practise procedures. So the ultimate threshold, of course, is the threshold for the fitness to practise procedures.

In terms of what information should be given to us in terms of unresolved concerns – paragraph 7(c) – we would expect that to be used quite liberally. In other words, unresolved concerns will be referred to us. By no means all of them will then result in a referral into the fitness to practise machinery. We are getting a bit ahead of ourselves, because it comes in the next paragraph. However, it is quite clear that we shall be providing guidance to people we are asking to certify through the clinical governance arrangements that there are no concerns, as to what we are looking for and what sorts of things they ought to be letting us know about.

THE PRESIDENT: The point I was groping towards, not very elegantly, was the fact that the colleges have already set the standards for much of this. A great deal of the work that has already been done, through the anaesthetists, through the College of General Practitioners and so on, will help us. There is quite a number of references throughout this paper to the work that the colleges themselves have done in that regard. It is later than the paragraphs you have got to, but it is all mentioned there.

PROFESSOR MICHAEL PRINGLE: It is quite clear to me that, when someone puts together a folder, quite apart from putting forward clinical governance evidence which will be the majority route – but some people will choose to put forward a folder and some will be sampled – they need to know what the evidence is that will be used to formulate the judgment; they need to know what standards will be expected. Equally, we need to know how we are going to assess that evidence, so that we are absolutely clear. That means having to set the criteria by which we will judge those standards and the evidence defined.

As you say, some of the colleges have done it. The paper says that the colleges will be asked to do it. If that is the decision of this Council, then we need to get on and ask them to do it as fast as possible. I believe that most colleges stopped that work about two years ago, because they were originally asked to do it and found difficulty in progressing it.

I understand from Peter that the colleges are very happy to take it on. My experience is that they will be, but they do need to be asked to do that very shortly. I am sure that it is a good role for the colleges to perform.
THE PRESIDENT: Are we generally content then with the points up to paragraph 14? That is the recommendation in 2(a) – that the four principles that Stephen has enunciated are agreed? [Agreed]

MR STEPHEN BREARLEY: It is a bit of a long haul now until we get to the next recommendation and I will try to make it as painless as possible. The next section is on the nature of the evidence that the GMC will be looking for.

The first paragraphs, 15 to 17, point out that we have already advised doctors that they should collect and retain data about their practices. We have already advised them, through Good Medical Practice and otherwise, that a good way of doing this is to maintain a folder. We have previously expressed the view, and now re-express it, that indications of what sort of data and how it should be evaluated would best come from medical royal colleges, on a specialty-by-specialty basis.

Paragraph 17 mentions some of the work that has already taken place. Clearly we are looking for more work to be done to firm this up, and we have previously had fruitful discussions with the royal colleges and I am sure we will continue to do so.

Paragraphs 18 and 19 then talk about questionnaires. As you know, I have been something of a fan of questionnaires. Work is going on, looking at suitable questionnaires for use in the UK context. Clearly they need to be properly designed, tested, validated, refined and show to be dependable in the UK context before they can be introduced, but we hope to be able to make suitable questionnaires available to doctors, probably during the latter part of next year.

Over the page we get onto a discussion of how folders of evidence may be looked at. The revalidation technical group has previously shown that such folders can form a basis for judgments about whether or not doctors are up to date and fit to practise; but we go on to point out here that these folders, and indeed the doctors who are compiling them, are involved in local clinical governance arrangements and subject to local scrutiny.

Paragraph 21 contains in the centre of it another principle, which I would like to draw to your attention.

“The submitted evidence must be sufficient to establish that a doctor is collecting information about his or her medical practice, reflecting on it, acting to keep up to date and that there are no local concerns about the doctor’s fitness to practise.”

So it is more than just compiling the folder. You have to do something with it and you have to produce evidence in addition that, quite outside the folder,
within the clinical governance machinery there is no concern about your fitness to practise.

We then go on to discuss the so-called appraisal route and then the independent route separately. I think we have all realised that the “appraisal route” is perhaps not the ideal term. We are really talking about a clinical governance route in which appraisal forms part.

Paragraph 23 develops that argument and points out that “...appraisal is not freestanding. It takes place in the context of other interdependent clinical governance systems”.

Hence, in paragraph 24, the notion which has been around before – that simply going through the appraisal loop five times would automatically get you revalidated – is not a helpful one, because it does not take into account the other bits of clinical governance.

Paragraphs 25 and 26 then set out why it is that we want not merely evidence of appraisal but evidence that the doctor has reflected on the appraisal information, acted to keep up to date, and that there are no local concerns about the doctor’s fitness to practise. This is something which we see coming through certification by the clinical governance lead in the organisation in which the doctor works or with which he or she is in contract.

I have in front of me something I have just been handed. It is issues from the Department of Health and something that I am told Aidan Halligan would have talked about this morning, if it had been ready in time. Essentially, it is the bare bones of a deal with the Department of Health over what they will guarantee to provide through clinical governance for the purposes of revalidation. They are talking about ensuring that a letter or report or certificate will be forthcoming from a chief executive or a governance lead, confirming that –

- appraisal has taken place;
- appraisal has led to the production of a personal development plan;
- the data within the appraisal are validated
- the process is robust;
- there are no known concerns about health or probity;
- there are no current disciplinary processes in progress;
- there are no relevant disciplinary findings.

On the basis of that information, it says at the bottom, “The process will be quality assured by CHAI”. On the basis of that information we feel that, for the doctors working in managed organisations with clinical governance, it should be possible for us to revalidate doctors with confidence.

The recommendation under paragraph 26 invites Council to agree that –

“...for doctors wishing to take the appraisal route, the GMC would require direct corroboration that the doctor has participated in
THE PRESIDENT: Given that the Chief Medical Officers are mentioned in paragraph 26, I wondered if there was anything that either Ruth or Mac wished to say at this point.

DR MAC ARMSTRONG: I have also had the chance to see this summary of the discussions that have been going on. I am happy to confirm that this, I am sure, is something we can deliver on.

I do not know how much this would apply to Ruth but I have written down the words for Finlay’s eyes, “Please Scotland-proof this paper”. It would be extremely helpful to us if this looked as if it was coming from an organisation that knew it was working in a UK context.

DR RUTH HALL: I would just add, “Please Wales-proof this paper” too. That is very important. I have nothing else specific to add.

THE PRESIDENT: The concept does not cause you concern?

DR RUTH HALL: No, and we will be pleased to think about it together. I think it is important that we think about it in a UK, conjoined framework. We will be doing that. I certainly understand and support the concept.

MS RUTH EVANS: I have two points. One relates to the earlier paragraphs 15 to 19, where, as we know, we are leaving the components of appraisal up to the colleges and local practice. That is what you are really saying in this, particularly in paragraph 17. What goes into an appraisal is something that the colleges are working on. Is that right?

MR STEPHEN BREARLEY: Appraisal – the documentation which has already been agreed covers the seven major headings of Good Medical Practice. So in terms of the range of it in that sense----
MS RUTH EVANS:  No, at specialty level.

MR STEPHEN BREARLEY:  It still covers the seven headings of Good Medical Practice. It is purely a question of standards, criteria, evidence – what you use to demonstrate that you are meeting each of the seven major headings, which will vary specialty by specialty.

THE PRESIDENT: It may be helpful to make the point again. Appraisal is not our concern. The linkage is if we use it as a stepping stone, but appraisal is an NHS concept, not a GMC one.

MS RUTH EVANS:  This leads me to my second point. For those of us who are not clinicians, the contribution this morning did not help elucidate the point at all. It is the actual relationship between the appraisal route. We now define revalidation as “the appraisal route plus”. In crude terms that is what has been discussed and refined over the years. That is what is here – appraisal route plus.

I am now very confused. If it is not “appraisal route plus”, is it “clinical governance minus”? This is getting extremely complicated, and I think that what the deputy CMO said this morning did not inform the debate at all. In fact, in my mind I am now more confused than ever. I wonder whether – because this paper is all predicated on appraisal, which it is then systematically knocking down and saying, “This is not actually going to be terribly helpful”----

THE PRESIDENT: Let me see if I can help, and somebody can correct me if I have got this wrong. Appraisal is one component of clinical governance.

MS RUTH EVANS:  Then why is the whole paper written as though it is the appraisal route plus?

THE PRESIDENT: Because we used that terminology – perhaps inadvertently or not helpfully – in the document that we put out in the spring of this year. We have kept the same terminology, but the basis on which it is formed is the clinical governance framework. Appraisal, and in particular the appraisal interview, is simply one component of that. The evidence base on which revalidation depends is the same evidence base that appraisal will depend on,
i.e. the clinical governance framework, for those working within the National Health Service.

**MS RUTH EVANS:** That is what I understood, except the deputy CMO then turned it on its head and said that, in terms of overall importance, appraisal has to be at the bottom and clinical governance at the top – which was a bit confusing.
If that is the case, which is helpful, then we need to redefine our terms in revalidation and redefine what we are seeing in these papers, do we not?

**THE PRESIDENT:** We need to be clear on the words that we are using and the meaning we attach to the words. If we start redefining all the definitions, we will simply cause even greater confusion than we are currently in.

I think that it is for us to be well aware of what we are talking about, whereas appraisal is simply one component of clinical governance. I thought that the definition Mac gave this morning was a particularly helpful one, when he regarded revalidation as providing, in a patient safety sense, the “floor”, and allowing appraisal to look to the “ceiling” – in other words, the promotion of a better-quality healthcare. Of course, that is part of revalidation as well, but in the patient safety context it is seen as the fitness to practise level “floor” for us.

There are the two components of revalidation. One is the improvement of the overall delivery of health and healthcare – clearly important to the vast majority of doctors – but there is that patient safety element. For some, we need to be looking at the very minimum standards that are acceptable. Does that help, or does that confuse you further? I do not think that you should be confused on the difference between appraisal and clinical governance. Appraisal is one component of clinical governance.

**MR BOB NICHOLLS:** The recommendation talks about the appraisal route, so it is still right up front. A lot of this is, “Is the appraisal route going to be all right?”. We are very worried that it should be quality assured and that we should be assured – which is what Stephen has just read out – that there is a system for making sure that it has been done.

I think the language is changing, and that is fine. I like Mac’s version. Clinical governance is what we are relying on, of which an important component – I do not mind where it is in the ranking – is appraisal. Therefore, to have a recommendation that is still talking about “the appraisal route” will signal to people out there that it is appraisal that is the main element and there are a few pluses. Actually, he makes a balanced point about the importance of
questionnaires and other things, but it does not come out in the recommendation.

Clinical governance is a big concept which includes a whole variety of things, one of which is appraisal. I would prefer the emphasis to be that we are now moving; we are on a journey; it is about clinical governance – we want that to be working in the managed system, and that appraisal is an important part of it.

THE PRESIDENT: So the concept is acceptable to you but we need to come back on the wording?

MR BOB NICHOLLS: I am with Ruth. I think the wording is still confusing.

MS RUTH EVANS: I had not quite finished what I was asking, though that is incredibly helpful and says what I wanted to say better.

There is the other component – we are then saying that our reassurance is that the revalidation of a doctor will not necessarily be through a clinical member of staff; it will be a clinical governance, non-executive board member, from what I understood the deputy CMO to say – and in fact this paper says that. It could be from the clinical governance lead member, which could be a non-executive director.

I am now in a total muddle, therefore, about the input from medical directors or clinical directors of a team.

THE PRESIDENT: We require an assurance, along the lines that Stephen just sought, from someone who has access to the information, that all these things are in place and there are no concerns at the local level. The people who can do that or who are best placed to do that are either the chief executive or somebody just slightly below that. I guess that it could be the medical director; it could perhaps be the clinical governance lead. Basically, however, the responsibility for this sits with the chief executive, and I think that is true in all the countries.

DR MAC ARMSTRONG: In organisational governance terms, it is not safe to leave the governance entirely with the executive side – whether it is the chief executive or his deputy, the medical director, to whom he deputises this. In governance terms, in open and public accountability terms, it is normal to involve a non-executive director to be chair of the clinical governance
committee, or chair of the risk management committee which may involve the clinical governance committee, whose job it is to provide to the board the assurance that these procedures are being followed to the correct standard.

It is not that non-executive’s job to do all of the procedures, but to assure the board that they are being done. It is the executive people who actually do it. In my experience, however, in terms of signing off appraisals for doctors, the chief executive normally delegates that to the board-level medical director.

**MS RUTH EVANS:** That is not what this paper says, which is why I am querying it. It says, “The corroboration should be in the form of certification by the clinical governance ‘lead’” – which in my view was going to be a non-executive director. Is this an appropriate role?

**DR MAC ARMSTRONG:** It could be, if what the clinical governance lead – that is to say, the chairman of the clinical governance committee or risk management committee, who may very well be a lay person – is doing is saying, “I am assured that these procedures are up to snuff”.

**MR FINLAY SCOTT:** I think that there is a serious debate to be had about whose signatures we would expect but, at the pure level of drafting, wherever it refers to “clinical governance lead” it should also go on to say “, medical director, chief executive”.

**MS RUTH EVANS:** It does in brackets.

**MR FINLAY SCOTT:** Exactly. I think that what the paper is saying in relation to that is that, at some point, we will define whose signatures we are prepared to accept, and these should be seen as indicative rather than authoritative at the moment.

**MR BOB NICHOLLS:** I have a question on paragraph 23. This is about clinical governance and who will do the quality assurance of that. It refers to an “independent audit by a responsible national body with statutory functions and responsibilities”. Are we being coy, or do we not know? Is that in England? Are they different in the different constituencies?
MR FINLAY SCOTT: Yes. This was our incomplete attempt to get away from a too Anglo-centric view of the world.

MR BOB NICHOLLS: We will fill in the appropriate blank, according to the country.

I have a hypothetical question for Stephen, which is more interesting. From what I heard this morning, the National Audit Office – I think in England and Wales, although I may have got that wrong – did a very good study in terms of where clinical governance had reached. I think that work was researched over 18 months ago. I quizzed him this morning and asked, “Where is clinical governance? If you are awarding stars, where would it be and where would appraisal be in primary care?” – which he acknowledged once or twice was probably not up to speed relative to secondary care in England.

I can see a hypothetical where a doctor is very anxious to do all the right things to be revalidated. He has his folder. He has opted, because he is in a managed system, to take the clinical governance route. However, it is a no-star trust which gets zero ratings for its clinical governance procedures. The doctor is getting rather near the end of the period when he has to produce my folder, and actually it is not his fault. What does the poor doctor do? Can he then at the last minute – because it seems to me that it has practical difficulties – say, “I had better say I am in an un-managed system. I want to go down the independent route”? Have we anticipated that? At this moment in time the kind way would be to say, “It is very uneven”. I know more about England than the three other constituencies, but it does worry me that you could get to a point where the doctor was not able to satisfy our requirements through no fault of their own.

MR FINLAY SCOTT: I think the key to answering Bob lies in paragraph 12. The nature of the evidence to be accumulated by doctors will be the same, whatever their circumstances. I think that Bob’s question is not about what the doctor needs to do, but in a sense what we need to do. Given the contrast that Bob has painted, if we cannot rely on a local signature because CHAI, or a corresponding mechanism in one of the other countries, has not made it possible for us to rely on it, then in effect the folder of evidence has to be treated as though the doctor was not within a managed system and we have to operate as though he was in the independent route.

In a sense that does not make any difference to what the doctor has to do in accumulating his evidence. I think that has been quite a shift in our conception in recent weeks. We have more clearly separated what we are expecting the doctor to do – which is to accumulate some evidence – from what we are going to do with the evidence. That is quite an important distinction. Does that help?
MR BOB NICHOLLS: I am sorry, I should have remembered that. I had read that. However, it does not really answer my question. If he is in a managed system going the clinical governance route, he will expect his folder to be quite robust after two or three years, but he cannot anticipate – thought he might – whether his trust will do all the good things.

THE PRESIDENT: He ought to be accumulating the information now for his appraisal process or for the independent route. The information that he requires is independent; it is not linked to either the so-called appraisal route or the independent route. It is dependent on the seven major headings of Good Medical Practice, as indeed is his or her appraisal process now.

I think that these things can be moved aside, therefore. Mac, have I got that wrong?

DR MAC ARMSTRONG: No, President, you definitely have not. This is a moving field. What you are looking for, quite rightly in my view, is external accreditation, quality assurance of the appraisal process, upon which you are depending.

I cannot speak for the process in England, but I am quite sure that it is not far out of line with the process in Scotland, which is that our equivalent of CHAI – NQIS – accredits health systems annually on their clinical governance procedures. Quite rightly, you will ask whether that gives you the positive assurance you need on appraisal. I do not think that it does at the moment, but your opportunity is there, in the dialogue – as you say in the paper – with CHAI and its equivalents. You have to get into dialogue with them about making sure that, when they do those annual sign-offs, it includes some positive assessment of the robustness or otherwise of the health systems’ appraisal processes.

Everybody is on a moving conveyor belt in this, but I am sure that is the route that you need to go down.

THE PRESIDENT: If it helps, those dialogues have started and we do have an assurance that that will take place – both for the English equivalent and the Scottish one.

PROFESSOR ROBERT SHAW: Turning to the wording of the recommendation we are about to be asked to approve, can I go to the last
sentence? “...that no concerns about the doctor’s fitness to practise have arisen through clinical governance systems.” Does that mean currently exist, or does it mean at any time during the last five years? And if they have arisen during the last five years of the five-year cycle, what implications does that have for the process continuing?

THE PRESIDENT: It is exactly the same as would happen now with the appraisal process: i.e. if there are concerns, they need to be dealt with outside that system. If they have been dealt with appropriately, then the system can continue. If they have not, then they need to be dealt with locally and, if that fails, then through NCAA and, if that fails, it is up through the General Medical Council. So there is nothing inherently different about this than currently exists at the present time.

PROFESSOR ROBERT SHAW: It does determine as to whether and what that statement means, because that statement means just for the last year prior to the submission of the certificate – which covers five years.

THE PRESIDENT: What it means, I think, is that if there are unresolved issues then they need to be resolved before revalidation and/or appraisal can continue.

PROFESSOR ROBERT SHAW: So that currently exist then, rather than the wording that is there at the moment?

MR FINLAY SCOTT: It is clearly a failure of the drafting, but if we look at 7(c), which Stephen helpfully took us through, it is “Where there are significant, unresolved, local concerns...” which I think the recommendation is essentially saying. We should perhaps take the recommendation in that sense.

PROFESSOR MICHAEL PRINGLE: I am very happy with this paper and with the progress that has been made, but I do think that we will have to bite the bullet about referring to the appraisal route. We will have to change our language. I do not think that it is a problem, frankly, but we will have to talk with clarity about the clinical governance route, and I think this part ought to be adjusted in order to allow that to happen.
PROFESSOR JAMES DRIFE: I was going to take the opposite point. As we have been talking about the appraisal route in our road-shows and discussions with the profession, it has been a given all the way through that we are talking about more than appraisal. “Appraisal” is a useful shorthand, which is in the documentation. It has always been a caveat, right from the start – appraisal, provided that it is robustly implemented. This is talking about the robustness of the implementation of the appraisal route.

Before Mike made his contribution, I was going to say that we do not want to give people the impression that we have suddenly changed the rules of the game. What we are doing is amplifying what we already understood was going to be the case. It is actually good news, because it is moving a bit faster than some of us thought it would move.

However, if we do change to calling it the clinical governance route, it should be a gradual change that comes over us, rather than something that we issue as a change in terminology. It will send panic waves, I think.

The advantage of appraisal is that it refers to a specific moment in time. Clinical governance talks about the whole process. I think that it is much more useful for doctors to be thinking of it as pinned onto the appraisals, with all the extra things that we have been talking about in terms of safeguards and further information.

THE PRESIDENT: How we handle this is something that we do need to consider. Finlay suggests that we link both and end up with “clinical governance” and “appraisal route”. The thing that has bedevilled us is that, in discussions, people have not distinguished clearly between the appraisal interview and the appraisal process. Of course, it was always far more than just two people sitting down in the sanctity of the confessional and doing this. It did depend upon an evidence base. Somehow or other, we need to make that clear.

DR ROSALIND RANSON: This is making the point I made this morning with the deputy CMO, that clinical governance gives quality information about groups of doctors and not about individual doctors. He said that he recognised that problem and that they would be trying to address it. It does not acknowledge that in this paper.

As it stands, we are asking the clinical governance leads to sign off something to say that there are no concerns about the doctor’s fitness to practise but, as clinical governance stands at the moment, they would not be able to do that on the basis of the information that they held.
THE PRESIDENT: I stand to be corrected here, but I think that is only partially true. If you look at the information streams that are there even in primary care, there is a lot of information about the individual doctor. To give you some examples – prescribing practice, referral rates, and so on.

DR ROSALIND RANSON: Not for non-principals. They do not have it; they are hoping to have it. That is a large group of doctors, working within a managed system. We will have clinical governance information about the practice but they are not included. They could use that in their appraisal documentation and they could expect that the clinical governance leads would sign that off – but it would not give any reassurance of that individual doctor.

THE PRESIDENT: I think that things are moving quite rapidly at the present time. I heard that this morning. It is an issue we need to address.

DR KRISHNA KORLIPARA: As a member of the Registration Committee, I support the recommendation. Like Jim and Mike, there is no question but that I think this is an improvement on what we have agreed. However, with the greatest of respect to Mike, I would be concerned if we were to give the impression that somehow we have shifted the ground radically – because we have not.

The facts are these. In the managed environment, appraisal is the fundamental brickwork – the starting point. What we have done is to evolve it further, to validate and to quality assure the appraisal process, in case there are any areas of concern or any unusual patterns of practice. With reference to what Ros has said, the local doctors will be assigned to one particular area – no matter what their portfolio of practice is – so that there is a central base.

There is therefore a lot to be gained by being positive – which is being truthful – that we have further evolved; that this revalidation will depend on the appraisal, quality assured by clinical governance. It will not confuse anyone. As you know, I have been doing road-shows in different places. I have been very well received when I have explained that clinical governance will validate and add extra value.

THE PRESIDENT: Thank you. Those of us who have been up and down the road also feel that. Do you want the other questions first, Stephen, or do you want to stop?
MR STEPHEN BREARLEY: Fortunately, President and Chief Executive, you have not left me with any questions to answer! I wonder if I could have a go at this one?

There is a concert pianist whom you may have heard of, called Stephen Bishop. He decided that he wanted to use his mother’s name, which was Kovacevich. For some years, he went around calling himself Stephen Bishop-Kovacevich, then he dropped the “Bishop”.

I think that there has definitely been a change of emphasis, though not the fundamentals, around the so-called “appraisal route”. It is clearly more than the appraisal route. I think that in this document, when it goes on the website and subsequently, we should start talking about “the appraisal and clinical governance route”. In a year or so, we might feel that we can drop the “appraisal” because people will have got used to the clinical governance bit. I hope that would satisfy everybody.

DR JOAN TROWELL: I am afraid that I am going to complicate your life, Stephen. I have spent quite a lot of time persuading doctors who are not in full-time clinical practice that they need to stay on the register, and they need to do it through a managed, quality-assured system of appraisal.

I would those words to continue somewhere in your paper. They are not in clinical governance systems. Therefore, once you drop the annual appraisal, you will drop their registration credentials. You will make it very much harder for a lot of our medical teachers, researchers and others, for example in medical informatics, to stay on the register.

That is one point. The other is that, as long as you leave the word “appraisal” in, it leaves the initiative with the doctor. Once you start talking purely about clinical governance, it puts it very much into the management role – and I do not think that is what we want to do.

PROFESSOR PETER HUTTON: I agree with Mike Pringle to a certain extent. I do think that this is evolving. My belief is that revalidation is actually an assessment, and I think we should say that – and that is different to appraisal.

The problem there has been, when this came up before and was discussed at college level, is that the colleges are happy to get involved provided that we are honest about it. Basically what we are talking about is setting up criteria which people will match and, if they match them repeatedly over a period of time, they will be revalidated.
In addition to that, there is an appraisal process which deals with personal development and other things, and there is a managed environment that you sit inside. However, we should not con ourselves and we should be honest. I think that the public expect revalidation to assess a doctor and to give him or her a tick or a cross. That can be done by a variety of routes. I believe that the terminology we set out with approximately 18 months ago was incorrect, and I think that we should try to put it right. The suggestion that Stephen has made, that there is a gradual shift, is probably the best way to do it. I also agree with Joan that we need to maintain the emphasis being on the individual doctor to get themselves to that particular level.

In summary, I believe that we set out with confusing terminology; that this discussion has demonstrated it; that we should start to move towards a more consistent terminology, emphasising that the responsibility for appraisal and revalidation is that of the doctor; and that the tools for revalidation need to be assessment tools, set by professional groups.

PROFESSOR CHRISTOPHER BULSTRODE: Since receiving this paper and what I have heard in the last few days, I have become increasingly concerned that there is a confusion in language; there is an avoidance of the word “assessment” and, from the point of view of the public, it has to exist here.

I agree with Mac Armstrong that we are in a very rapidly changing time, which means that we have to handle it with great care. I do not agree that revalidation excludes the worst whereas appraisal includes the best. I think that revalidation is much closer to Bob’s idea, that somebody should be validated to do the job that they are required to do at that time. That is a very high standard level, not a bottom end level.

I think that there is a confusion of jargon here. In that confusing and rapidly changing environment, we should be very careful about signing off any documents just at the moment. I was with Ruth. I read the Duncan Lecture recently from Donald Irvine, where appraisal was a true assessment for the public. I heard Aidan Halligan describe a near-religious experience this morning, which had very little to do with assessment that I heard. Those two do not fit together in my mind whatsoever.

Until all of us in this Council are absolutely clear what we are talking about and what we are trying to achieve, the danger is that we shall produce a document that is a paper exercise; that is safe; that the medical profession will accept because it is fairly anodyne; but that actually passes off the real responsibility of this job; and, every time there is a thorny issue, firmly passes the buck to the colleges saying, “It’s the colleges’ job to set thresholds” – most of the colleges have failed to do that and are finding great difficulty in doing so – and also passes it down to local level to pass judgment.
We are the statutory body. We have to take a lead in this. We cannot duck these issues. I do not think that we are ready, with the language as it is at the moment and with the field changing, to put a definitive document out. We have a bit more work to do.

THE PRESIDENT: I am slightly concerned at the turn that this debate is taking. We do have performance procedures which are quite robust, and we are actually able to discern which doctors are fit to practise and which doctors are not. They are perfectly robust, so that when push comes to shove we are able to do that. That has been supported, and there is no difficulty in that. It is true that the language has caused some sort of difficulty, but you have seen the papers from two or three years back. There has been absolutely no change whatsoever in the principle. That is, the appraisal process was seen as being important, as long as it was linked into clinical governance. It is precisely as Krishna outlined. This is simply looking at the quality assurance aspects behind that. Of course revalidation is an assessment, in the sense that you can fail it – and some doctors no doubt will.

If we are looking to see poorly performing doctors identified every five years, however, we are really missing a trick here. If we are seeking to identify poorly performing doctors, it has to be done on that poor performance as identified – not “x” years later when revalidation kicks in.

Let us not go back to fundamentals here. We have made a huge amount of progress. We are not in any doubts about the distinction between what we are trying to do and getting baseline levels about identifying poorly performing doctors. We can do that. That is what we do the whole time.

DR PETER TERRY: Given the way the debate is going, I feel that I need to reaffirm what I thought was happening. I am happy about moving from appraisal to clinical governance, simply because governance is all about the organisation and how that is run, whereas appraisal and revalidation are very much about the individual. I think that we should keep that very firmly in our sights.

Revalidation is an assessment, but it is using the appraisal evidence. That was my understanding. We must continue to support appraisal because, if we do not do that, we will not get the evidence for revalidation, and the evidence will not be collected. I see clinical governance fitting in quite simply as quality-assuring the appraisal process on a local basis. They just make sure that it is being done properly.

That may be a very simplistic way of looking at it, but I am becoming rather confused by this debate, I have to say, and I think that we ought to keep what we are trying to achieve very clearly in our heads.
DR ARIYANAYAGAM: There are two points I want to make. The first is about appraisal itself. There has been reference to the fact that there is a lot of confusion about the term, and I think that confusion already exists outside. I have known instances where appraisal has been used as assessment, to the extent that the individuals have been subsequently subjected to disciplinary procedures.

You can keep on talking about it. You could argue that an appraisal could be used in order to help and support an individual. Equally, you could argue that an administrator or medical manager can use the same appraisal process as a means of assessment, with a misplaced objective. That is arguable. My second point is this. If we have that doubt, why do we not say that revalidation will be through the clinical governance route, of which appraisal will be a prerequisite – at least at the beginning? That would be more meaningful. Otherwise, to say that it will be either through the appraisal route or the clinical governance route can be very confusing.

THE PRESIDENT: It is the issue that Peter outlined. It is where the responsibility actually falls. It ought to fall on the individual doctor and not on a process. Some of us would think – perhaps not everyone around this room but I personally would think – that the responsibility is primarily on the doctor, and the clinical governance process comes in behind to back that up, to provide the reassurance that the GMC requires. However, not everyone may agree with that.

MRS ANN ROBINSON: When Finlay made the earlier point that there is a big discussion to be had about clinical governance and quality assurance – how far we are down the track, whether all the pieces are put together, whether we can ourselves certify, if we are satisfied that the clinical governance process will give us the quality assurance to be able to rest on appraisal – that is a big discussion that we have not had.

Part of the problem we are having this afternoon is that we have not been through that process. We only started fully to recognise the clinical governance point on the last occasion we discussed it as a Council. Mac's made the point this morning about ensuring that there is some sort of basic risk assessment. There is a baseline there.

Clinical governance and so on are heading for excellence and all of the great things. We know that we are not there. In the meantime we have to build in some safety-net provisions as part of it all. We have not had the discussion about how we do it and how we take it forward.
There is a bigger issue than simply the public having confidence in doctors. The public need to have confidence in the whole health system. We have to work together on that. I am on the Registration Committee and I think that these are good recommendations. I like Stephen’s idea that we try to incorporate some of this now, given that we recognise that it is a bigger picture, so that we find a way to move people safely down this line in an assured way – without terrifying people that we have thought of some brand-new ideas – but also making people recognise that it is not the end of the story.

What we are getting to is the right framework, the right structure, et cetera. There are other bits of the game that we have to be working on, however. We cannot do it on our own; we have to do it with everybody else. Ministers and every major stakeholder in the NHS have as much riding on this as we have.

THE PRESIDENT: I very much agree with that, Ann. Stephen, do you want to try to bring this together and come back to the recommendation in front of us?

MR STEPHEN BREARLEY: Revalidation is a very large canvass. It is very easy to lose sight of one bit of it while you are looking at another bit of it. I fear that may be part of the difficulty that we have experienced in the last few minutes.

Perhaps I may go right back to the beginning of the paper, to paragraph 5.

“...we are working with partners toward a number of broad aims...Ensuring that dangerous and dysfunctional practice is identified (promptly)...Ensuring ...that all licensed doctors...are up to date and fit to practise.”

These are the twin aims. The third one is “securing improvements”. We are working with partners to achieve that. To suggest that revalidation alone is the tool for achieving all of that is simply unrealistic. It is a process which happens from on high, operated by us – a body which is largely physically remote from the place where doctors actually do their daily work and where their performance and standard of practice can be assessed. We cannot do all of these things on our own. We have to rely on the input of other people with whom we are working to ensure that all of these aims are met.

We have identified a principle that, in order to revalidate, doctors must submit evidence which is sufficient to establish that he or she is collecting information about his or her practice, reflecting on it, acting to keep up to date, and that there are no local concerns about the doctor’s practice. The collection of the information, the submission of that information to scrutiny through the appraisal process, the outputs for appraisal, the role of the whole clinical governance machinery together, quality assured by CHAI or its equivalents in the devolved administrations, puts the GMC in a position where we can say
with an acceptable level of confidence that the doctors who are certified are up to date and fit to practise.

I think that the direction of travel, as set out by the recommendation in front of you, is the right one. Indeed, I think that it is the only one which is available to us. Clearly more flesh needs to be put on bones. In particular, our terms need to be defined; our standards need to be defined; guidelines need to be written; pro formas need to be created. There is plenty more work for the Registration Committee and others to do before this thing goes live in just over a year’s time. However, as a direction of travel, as a principle, as a framework on which to hang these additional bits, I have to say that I think it is right – and I would ask you to support it.

THE PRESIDENT: Are people generally content with that, given the caveats that people have expressed? [Agreed]

[A short break]

MR STEPHEN BREARLEY: The next four paragraphs deal with the so-called “independent route”. We have always said that doctors have a degree of choice about what type of evidence they are going to submit to us in support of their own revalidation. There may be a few who are working in managed structures who nonetheless prefer to use the independent route. I think that will be exceptional. I cannot see any advantage to doing that in circumstances which are likely to apply, but we need to have an alternative route.

Paragraph 28 refers back to paragraph 12 which, I would remind you, emphasised the nature of the evidence that we are looking for is basically the same for everybody: it is purely a question of the way in which it is processed which may vary. Paragraph 28 introduces explicitly something which, again, has been intrinsic to our thinking for some time, namely that appraisal is something which we believe that all doctors should undergo. It is part of the process of maintaining one’s professional standards and reflecting on one’s practice.

The expectation would be that, in collaboration with our partner organisations – colleges, faculties, perhaps also specialist and professional associations – it would be possible to provide quality-assured appraisal processes for doctors who are not working within managed structures. Paragraph 29 refers to the fact that we would look to be developing quality-assured arrangements with such partner organisations, in order to make sure that this happens.

This section does not refer overtly – unless I have failed to highlight it – to the use of questionnaires. Questionnaire tools are something which would be
equally applicable to doctors in managed structures and doctors going down the so-called independent route. As we have indicated earlier, we expect to develop these and to make them available. Aidan Halligan this morning mentioned the 360° appraisal, which is something that relates quite closely to what questionnaires do. It is another form of evidence gathering which we would wish to endorse.

Paragraph 30 accepts the position – and I think this may cover Joan Trowell’s earlier comment – that a small number of doctors may find it genuinely impossible to make arrangements for local corroboration of their fitness to practise. It may be the case that, for a small number of doctors, the GMC will need itself to look at the evidence in detail. We shall of course rapidly develop an expertise in doing so, because we will be sampling doctors’ revalidation data anyway and looking at that. We shall need to have a mechanism for looking at the primary evidence in a small number of cases, for doctors who are in particular circumstances which prevent local corroboration.

Once again, I am very happy to acknowledge that there are a lot of nuts and bolts to be added to this model, a lot of detail to be worked out. Guidelines, rules, pro formas – all of that still needs to be done.

The recommendation therefore is not a very far-reaching one, and it simply invites Council to note how far we have got at this stage.

**DR JOAN TROWELL:** I think that I must clear up a confusion here. I am talking about people who are employed within universities. It is not difficult for them to do annual appraisals in a properly structured and regulated way. They are therefore not suitable for the independent route, because the university will require them to have an annual appraisal anyway. For them to have a double whammy will just take them off the register. I am talking about people doing quite basic research, the probity of whose work is essential to the integrity of future medical practice. I think it is important that those who are medically qualified stay on the register.

**MR ROB SLACK:** At the Registration Committee we did talk about costings. I would be very loath to see the independent route used by people who just wanted to have a slightly different way of doing it. I thought that there should be some sort of financial penalty. For instance, if I said, “I am not going to do it through the NHS processes. I am just going to do it independently and submit it”, I think that should cost me extra money, because I am costing the GMC money.

I wonder if there is something you should put in there, somehow to discourage people from thinking they can do that?
THE PRESIDENT: It is something we could pick up subsequently. It is not directly relevant this afternoon, but it is a matter we should be picking up – particularly if we are going to use that as a third party to help us.

Otherwise, are you content? [Agreed]

MR STEPHEN BREARLEY: The next five paragraphs refer to these alternative types of evidence which have been spoken of earlier. I do not think that I need take you through the paragraphs in detail. The paragraphs refer you to annex A, in which there is a statement on the nature of the evidence for revalidation. It really reiterates things that we have already covered.

Doctors will be expected to maintain a folder of raw data. It will be structured on Good Medical Practice, conforming to any relevant guidance from medical royal colleges.

Going down to paragraph 4, “All doctors will have to provide a description of their medical practice…”, and (a), (b) and (c) set out what that must contain.

The aim in the one-sentence paragraph 5 is that there would be, within the list of acceptable alternatives, options which doctors in any field of practice could choose – granted that we have acknowledged just a moment ago that there might be a few who will not be able to choose the usual ones. We are talking about certification by clinical governance leads, or the equivalent; certification for trainees by a clinical tutor, college regional adviser or equivalent; certification for locums derived from end-of-placement reports; and, for doctors outside managed structures, certification from named individuals who will be accredited for the purpose. Finally, as far as probity and health are concerned, we shall require a declaration from the doctor which must be certified by somebody else who is subject to GMC jurisdiction.

I think that what is in annex A sums up what we have already covered. I will therefore invite you to look at the recommendation under paragraph 35, which invites you to agree essentially what is in annex A.

THE PRESIDENT: So it is recommendation 2(d) that we are looking at. Are people happy? [Several members: Yes]

DR BRIAN KEIGHLEY: I am a little worried about the health declaration. This is the first time I can remember seeing this. From previous papers, I thought that it was a self-certification which, if it was shown to be dishonest, would leave you vulnerable to fitness to practise procedures. The thought of having doctors certifying each other – how are we going to do that? Is it an
annual medical? Is it an overview of medical records? It is a new concept to me, and I think that it is overly elaborate.

THE PRESIDENT: I think that the concept was as Aidan described it this morning. That is, the doctor would say about himself or herself, but the clinical governance lead or whoever would indicate that, as far as they were aware, there had been no concerns. It is as simple as that. It gets round some of the issues, that doctors losing insight might not actually be able to help themselves in that regard.

Are you happy with that, Brian?

DR BRIAN KEIGHLEY: Yes, as long as it is not misinterpreted by clinical governance leads and doctors, in that they feel that they have to have a certain amount of evidence which is greater than the knowledge of having no knowledge. I am worried that that opens the door for people to insist on over-intrusive occupational health services, or whatever.

THE PRESIDENT: It is getting round the problem that we would face if a doctor self-certified in the face of quite clear objective evidence elsewhere that there was a problem.

DR RACHEL ANGUS: I think that we had rejected the notion that the doctor’s general practitioner would be asked to certify it, so I was a little surprised to see this item. Now that you have clarified that it is the same person that would sign up the overall revalidation, I think that I am content.

MR STEPHEN BREARLEY: We then come onto the final section of the paper, which concerns quality assurance arrangements. The Registration Committee spent half a meeting discussing this, but we were inhibited by the fact that it is difficult to describe quality assurance arrangements for a system that has not yet been clearly constituted. Until we know precisely what the operational details will be, it is difficult to tell you in any detail how we would quality assure them.

This section really deals with principles and intentions. Paragraph 37 points out the areas that we feel will need to be quality assured. Paragraph 38 sets out the objectives of that quality assurance.
There is a further annex, annex B, which we are proposing should be circulated to interested parties – all of our potential partners in this business and also patients’ organisations and representatives – setting out the approach that we are taking. Annex B is quite long – some five pages – and I do not want to take you through all of that in detail. I hope that people have read it, that they are content with it and will be happy for us to send that to all those likely to have an interest and to seek their views on the approach we are taking.

THE PRESIDENT: Taking these in order, we have recommendation 2(e) first, which is to note and endorse the Registration Committee’s progress on the set of principles outlined in paragraph 37. [Agreed]

Recommendation 2(f) relates to annex B. Are you content?

MS RUTH EVANS: I am not sure whether I am. Throughout this paper, my concern has been remembering the debates that were had amongst patients’ organisations about the level of involvement at local level of patients in participating in the revalidation process. I think we left it that it will be up to local trusts to ensure appropriate participation by patients – not the public, but by patients – and that feedback should encompass this locally.

Indeed, we did say that, in quality assurance terms, there ought to be some input – which you have in here in a sentence about the Patients Reference Group and local PALS. Is this sufficient? That is what I worry about. I kept wanting some sort of reminder, when we tell doctors what is expected, or the types of information that should be collected, or indeed the principles.

Throughout this paper I have kept my mouth shut on it. However, it does seem a bit niggardly to have to get to annex B to find any reference to external audit by patients of their needs, requirements and views being taken into account within the appraisal process, even though it is locally based. It is a difficult issue, and I am not sure whether we have got it right.

For good reasons, we decided that, practically, any quality assurance by patient organisations has to be locally led. Nationally, we could get the Patients Reference Group, or whoever, involved in making sure that processes are okay. I wonder whether we could perhaps be a little more up-front about reminding doctors, either in terms of principles or the information to be contained, but I did not want to single out a particular Good Medical Practice heading. That is why I kept quiet – because, of course, it will come under the Good Medical Practice headings. I would just like to hear a couple of views on this.
THE PRESIDENT: I do not want to open up the debate about questionnaires again, but revalidation insists that doctors do provide information about patients. The easiest way to do that, in my view, is that you get a questionnaire organised.

MS RUTH EVANS: I do not think that would be the view of the majority of doctors being appraised though. I think that is an enlightened view.

DR JOAN TROWELL: A subsection in the appraisal form is surveys of patients.

THE PRESIDENT: So it needs to be done. The question is how quickly we move to making it more and more robust. I guess that is the point you are making.

MS RUTH EVANS: I do not know whether we need to build something in – a reference that is not annex B.

MR STEPHEN BREARLEY: I am not sure where you would like to put it, Ruth.

MS RUTH EVANS: I hesitated over whether it should go into “Nature of evidence to support revalidation” on page 4; then I hesitated over whether it ought in fact be going into the “Developing further guidance” section, or into the quality assurance arrangements. It could have gone in any of those places, but I kept quiet because it is covered by the Good Medical Practice headings.

THE PRESIDENT: Do you think we could take the spirit of what you are saying and see how we fit this in? There is no dispute that it needs to be there. Nobody will argue against that.

MS RUTH EVANS: I was not sure whether it should be there, but thank you.
PROFESSOR MICHAEL PRINGLE: We are saying that every doctor will collect evidence which they will not necessarily submit, especially if they have the clinical governance certificate.

The content of that folder will be determined by the criteria of standards of evidence that we are asking the colleges to outline. I think that it is very reasonable to expect that to include evidence from their patient groups and from their peers. What we need to do, therefore, is to be slightly directive – not necessarily very directive – about the sorts of things we are expecting as criteria of standards of evidence, which would then allow us to make sure that that evidence is there. So I think that we can cover it.

THE PRESIDENT: I think that is right. When we come to look at these selected doctors in greater detail, that is exactly what we would be looking for in that situation.

PROFESSOR JAMES DRIFE: To reassure Council that we built in the patient questionnaires into the document for the RCOG in 1999 or 2000. We publicised and discussed it, and there were no concerns expressed. Doctors are used to the idea.

MS RUTH EVANS: I am satisfied that at college level and at local level it will be taken forward. I was not sure whether politically it would be helpful for us, in public relation terms, to be able to present this as something that we have given prominence to.

THE PRESIDENT: It has been absolutely part of our thinking, right from day one. There is nothing new about it. It is simply making sure that we make it overt, I think.

DR ALEX FREEMAN: There are standard patient questionnaires available which are produced, and which are already being used in general practice. I have just been through an exercise where I have had the feedback from my patient questionnaire. I found it a very worthwhile exercise and did not have any problems with doing it. If someone else analysed the questionnaire and handed the results back to me, I would think that was perfectly acceptable and I think that it is an important part of revalidation.

THE PRESIDENT: If you are reassured, then I think we have completed this. [Agreed] Thank you very much, and thank you to Stephen.
I know that I should not do this but I am going to reopen the debate slightly on recommendation 2(b), because we may have found a form of words that would get round some of the issues that various members raised – in particular, Bob Shaw.

MR FINLAY SCOTT: I did not want there to be any doubt about how we were going to meet Bob Shaw’s point. The wording is as follows:

“Agree that for doctors wishing to take the appraisal and clinical governance route, the GMC would require direct corroboration that the doctor has participated in appraisal, and confirmation that there are no significant unresolved concerns about the doctor’s fitness to practise”.

THE PRESIDENT: Are you content? [Agreed]
1. **President’s Business**

**THE PRESIDENT:** I have four items of business, which range from the mundane to the exotic. I take the mundane first of all. Our Council meeting scheduled for the 27–28 October falls on the mid-term holiday for England and we think that we will have difficulty in becoming quorate. My suggestion to you, therefore, is that we do not hold the meeting on that date but have the possibility of a two-day meeting on 30 November and 1 December. The office has explored with all of us dates for these Council meetings and that seems to be the best option that we have come up with. Unless you feel very strongly to the contrary, I suggest that we cancel the meeting for 27-28 October and have the potential for a two-day meeting on 30 November and 1 December.

The second item relates to the Shipman Inquiry. As we all know, there has been some interest in one of the letters that the Council received from the Shipman Inquiry late last year. I am very grateful to Finlay Scott and to the staff of the GMC, not least to Gill Webber, for the way in which they handled that interest a couple of weeks ago. I would just remind members here that our response – which I think is a fairly robust response to the various items that were raised by that letter – is now in the public domain. It appears on the Shipman Inquiry website and anyone can look at it.

The third item I want to bring to your attention is the fact that on 4 March we had a very successful meeting with colleagues from the Royal College of General Practitioners, from the General Practitioner Committee (GPC), and from the GMC, looking at how links between clinical governance and revalidation might be improved and strengthened. A minute of that meeting, which has been agreed by David Haslam and myself, is on the table for you to look at this morning; but I want to draw your attention to the agreed outcomes from that meeting.

We agreed that we would, as a group, seek to define how clinical governance certification should be delivered: how we would get the reassurance that we want from the clinical governance mechanism. Secondly, we would take forward the proposal that clinical governance support groups might well be helpful in a local situation in reviewing the information that is known about doctors, and help to make recommendations to the clinical governance leads, the medical directors, or the other relevant chief executives. Thirdly, we would look at what we require to develop by way of tools that would help that process to be taken forward. We agreed, I suppose fourthly, the point that comes in under paragraph 13: that we would do this in conjunction with other groups that are also exploring some of these issues.

I do not know if Sir Liam wants to comment on that, but I know that we are working very much hand-in-glove with the Department and with other colleagues. Ros (Ranson), Krishna (Korlipara) and Mike (Pringle) were at the meeting and can correct anything I have said that is wrong.

**PROFESSOR MICHAEL PRINGLE:** First of all, I thank you very much for hosting the meeting and for taking the issues forward. It was a very constructive and helpful meeting.

Two issues come out of it which are in addition to the summary you have given. First, we did discuss – and, if my memory is correct, it was part of our understanding – that there were implications for all professional groups and that, although this was discussing general practice, there will be implications for all professional groups through the decisions that may come out of such a group.
Second, what comes out of the minutes which is important for this Council to understand is the need for very prompt action to bring all the other professional groups on side and to make progress, because the timescale is very tight. You are obviously aware of that need and it is clear from the minutes that will be taken forward, but the Council needs to know that it has to happen very soon if we are to put this sort of agreement in place.

**THE PRESIDENT:** You are quite right. There cannot be an agreement for one part of the profession that does not link into the others.

**SIR LIAM DONALDSON:** When, after revalidation had been signed off by the Council, the early discussions took place, the idea was that appraisal of NHS doctors would be the basis upon which revalidation decisions would be made. However, further reflection, and particularly some of the discussions in the Shipman Inquiry, indicate that there is something needed on top of that. What that something is exactly is a task for us to explore quite quickly now; but when we talk about a link to clinical governance, we have to be absolutely clear what we mean.

To us, clinical governance is a way of ensuring that all NHS organisations and all clinical teams have in place the systems and the mechanisms to assure quality, to build in quality improvement, and to ensure safe services. It is therefore a measure of organisational health whether the test is at the level of a whole hospital or at the level of a particular team. However, I think that the direction of the discussions at the Shipman Inquiry and subsequently within the GMC – and these minutes reflect it – is that there is a more specific element of clinical governance which needs to be picked out: that is, the extent to which the health organisation, whether it is a hospital or a primary care organisation, has been actively using data to identify doctors whose performance might be giving rise to concern. Clarifying that as the issue to be developed further is, I think, particularly helpful.

We also ought to acknowledge that, worldwide, the availability of surveillance systems of that sort properly to assess outcomes of care on a routine basis and in a way where particular groups of practitioners can be compared against others, against good practice and so on, are not that well developed. So whilst this is something where there will be some sources of data being used within the NHS on a routine basis, much further work is necessary to develop other and fuller sources of data to undertake this sort of surveillance.

The Shipman Inquiry will be reporting in June, but my interpretation of the discussions is that they have been particularly concerned that there should be systems in place to recognise outlying practice. That is therefore the aspect we particularly need to look at now.

I am optimistic that we will be able to resolve all of this, but I think that we have to acknowledge that the mechanism through which we link the NHS quality surveillance and quality assurance procedures into revalidation has shifted quite substantially, and recently, as a result of these deliberations. We need to look very quickly at what more we need to do to align them.

**THE PRESIDENT:** Perhaps I may pick up the point that Mike (Pringle) made about these arrangements applying not just to one part of the profession. These arrangements, of course, need to apply not just to one part of the United Kingdom. Anything we agree on this particular working party, which relates largely to England, therefore needs to be applicable across the other countries of the United Kingdom.

Ruth, did you want to say anything about that?
DR RUTH HALL: I think that you have said it for me, President. We are clearly linking very closely with our departmental colleagues. Also, in any work that you do, we would be very grateful if you could take into account the different delivery mechanisms which are emerging and the different inspection and quality assurance structures being put into place — certainly in Wales, and also in the other countries.

THE PRESIDENT: We had not lost sight of that, although from time to time we may give the impression that we have.

PROFESSOR CHRISTOPHER BULSTRODE: Speaking as someone who is involved in running courses training consultants in how to appraise, there is tremendous antagonism and fear about this whole initiative. If we impose things from the top down, we are in danger of producing far more resistance to change than we really need. I sense that, when we get down to it, it is exactly what they want. What they do not want is to have it imposed. Somehow we have to find a way of taking the profession with us. Otherwise, they come up with all sorts of spurious reasons why it cannot be done — when in fact they actually want it to be done, and it could be done.

THE PRESIDENT: I think that has always been the tightrope on which we have been balanced.

PROFESSOR PETER HUTTON: This is a small point to do with collecting data on performance. In some people’s minds data means numbers. Quite often, the situation which we are trying to deal with is a measure of quality outcome. I raise this issue so that it is in our minds. If you stick purely to numerical data recording, you are likely to produce indicators which do not necessarily reflect the situation that you are trying to analyse.

Certainly, in one other area of my life where I am dealing with this, we are working towards trying to get relevant descriptors of activity. I think that if we could broaden it slightly so that we did not keep on saying “data”, it would be better. If we use the word “data”, people expect to see so-many per cent of this and so-many numbers of that. If we could broaden it a bit, I think that would be a more healthy development.

THE PRESIDENT: That is very helpful.

PROFESSOR JIM DRIFE: I would not like to leave hanging in the air the impression that doctors are very resistant to appraisal. As the process was going through, the feeling, subjectively from the people I speak to, is that they are accepting it and finding it useful. So there is a debate, but there is not a strong negative feeling coming across from the profession.

THE PRESIDENT: Yes, and it is the information base that we will require for revalidation which is our interest in this particular matter.
The fourth item I wanted to touch base on related the Race, Equality and Diversity Committee. Do you want to bring us up to date with what is happening, Ed?

DR EDWIN BORMAN: The Race, Equality and Diversity Committee had hoped to provide for Council at this meeting a paper that would examine policy in this area across the GMC, and also explore how we could be picking up from other organisations examples of good practice, both within their organisations and in their external relationships. That is not a specific problem, but it is taking a little longer than we had hoped. We will be bringing that back to Council at its next meeting and we look forward to your views on it, both in its genesis and also when it does come to Council.

The reason why I have asked the President if we could have a quick moment to give an update at this meeting is because, unfortunately, it seems to have been suggested, out of Council, that the Race, Equality and Diversity Committee is to be abolished. I am not quite sure where this came from – and I am well aware of the political precedent that, when your immediate senior says that he has great confidence in you, you ought to start picking the stiletto out of your back!

We certainly can envisage an ideal-world scenario where we do have race, equality and diversity issues sufficiently embedded in all of the workings of the Council effectively to make ourselves redundant. This being the real world, that will not be for a while yet. I would ask members of Council, if they find that this comes up in conversation – and it has come primarily from the British International Doctors Association – to indicate to them that we do see this as a significant component of our work, and indeed are looking to be at the forefront of the medical profession’s work in this area.

THE PRESIDENT: That is really just for information — a feature in the “Not Yet Dead” column in the next GMC News!
5a. Taking forward the GMC’s education function

PROFESSOR PETER RUBIN: The essence of what I am asking today is for your approval to hold a conference, later this year or early next year, to help inform the strategic activities of the Education Committee over the next few years.

As you will know, we are just coming to the end of a major programme of work, where we have reviewed all the statutory functions of the Education Committee, and we will be reporting back on that over the course of the autumn. We now want to position ourselves to continue to do what the Education Committee has done for many years, which is to lead rather than to follow, and to shape policy rather than to respond to policy. We would be looking for input from the Council in particular to the strategic activities of the committee.

This is not to be confused with the seminars that we already hold before Education Committee meetings, which are an opportunity to look in depth at one topic for a couple of hours before the committee meets. For example, we have recently held seminars on research and what research we would commission through the Education Committee. Very recently we held a seminar on student fitness to practise and the issues around the registration of medical students. In the autumn we will be holding a seminar on the pros and cons of a national licensing exam.

These are major policy issues that are not going to go away, and on which we need to be constantly updating our position. These will be happening in any event, therefore. Led by Chris, we are also looking at a very interesting area – what will medicine look like in the future. These things are ongoing, but we are very keen to get input on what the Council feels should be the major areas of strategic activity for the Education Committee in the coming years, and we felt that a conference would be the way of doing it.

THE PRESIDENT: Chris, do you want to add to that or subtract from it?

PROFESSOR CHRIS BULSTRODE: No, only to say that it is tremendous fun!
THE PRESIDENT: That is entirely the wrong response!

MR BOB NICHOLLS: It is very interesting and it made me wish I was on Education and not doing some of the other things that I am doing!

There is one thing that rather surprised and worried me. I have never quite understood what the words “co-ordination of continuing and postgraduate medical education” meant.

THE PRESIDENT: It is “co-ordination of all stages of medical education”.

MR BOB NICHOLLS: I am obliged. There is a lot of mention, properly so, of the importance of the undergraduate, the early years, pre-registration, and all that; but it is notable that there is an absence of anything about our role in continuing education. From my memory of fitness to practise cases and my current knowledge of NCAA work, those standards and reviews, as is suggested here about the balance of curricula, are equally important at postgraduate level as they are at undergraduate level.

I have warned Peter that I might ask that question, but it would be interesting to know where we are. I know that there is PMETB and all sorts of other bodies doing things, but what is our role? Maybe that is something that should be debated by the suggested conference.

THE PRESIDENT: The fact that we retain that statutory function of co-ordinating all stages is quite valuable at the present time. As the new bodies, in particular the Postgraduate Medical Education and Training Board, were introduced, it was without prejudice to our statutory remit. We are therefore still in there. Of course we have to link effectively with them, but it does not remove our statutory duty.

Peter, maybe I have got that wrong?

PROFESSOR PETER RUBIN: No, you are absolutely right. There are two things. One is to seek the approval of Council to the idea of holding a conference of this type and, if you are agreeable, then to look for ideas about content. As Bob is saying, this could well be one of the issues to be raised at the conference.
It would be extremely helpful to have somebody, for example from the PMETB, along to take part in the debate. We have put down one or two other ideas that we could discuss, but we are not looking for a complete set of ideas right now. We are looking for an agreement in principle to hold a conference, and then we will be coming back to you over the coming weeks for ideas of topics that you think are key ones to raise at the conference, to start to put some shape to it.

PROFESSOR ROBERT SHAW: The paper contains an interesting thought, of extending the remit of the GMC to considering entry requirements into university for medical students. These have been widened in a major way, both with the graduate entry programmes and the widening access programmes that universities have brought in.

Surely the GMC is much more about the outcome of courses of education and training of medical students? The end point, in other words, rather than the starting point. Particularly if we look at the Registration Committee, where more doctors are registered annually from medical schools and training overseas than come from the UK, I would find this a strange approach to adopt. I would certainly argue much more strongly for a common evaluation of all doctors at the end of their training – that is, prior to registration, not at the end of education – as the end point for commonality of assessment. I would argue very strongly that that is something that we must get back to, since the current programmes for UK trainees – with an unstructured PRHO evaluation process at the moment – versus the PLAB, are looking at entirely different end points for achieving the same requirement, namely registration.

DR JOAN TROWELL: As one of the Council members who is not on Education but who was invited to one of your last seminars, may I thank you for the invitation and for the privilege of attending?

I was struck, however, by the fact that there may be many other people in this room who would have come had the venue allowed, had they had more notice, and the date in their diary. I wondered if you had thought of bringing some of your educational discussions into sessions related to Council meetings, so that if we turn up at 9.30 in the morning we could have an hour from either one of the committee or somebody else, giving us some thoughts on a topic – particularly related to Education, but other directorates might like to take it up. Nothing to do with the rest of the day’s agenda, but about what are our core GMC functions. This might be an opportunity of noting that suggestion.

PROFESSOR JIM DRIFE: In order to avoid it being the same people talking to each other again, it would be good to have a special effort to have a
different kind of input. One of the most important kinds would be from students, from recently qualified doctors, people who have experienced the system already, and possibly someone from Europe at a similar level.

One of the things we shall have to grapple with is the fact that people qualifying within the European area are able to work here – and to develop that. Seeing if there is any cross-fertilisation we can get on that in the conference might help to freshen it up.

DR BRIAN KEIGHLEY: In the context of Bob’s comment about CPD, I would look for Peter’s reassurance that any conference would not be too prescriptive. I am conscious that, in continuing professional development, it should be conducted on the principles of adult education; it should be needs-led education. We are talking about curricula. I would not like to see something be too rigid as a result of this conference.

DR PETER TERRY: I would support Bob’s comment about, as it were, postgraduate education. There do seem to be quite a number of bodies involved in this. It seems slightly confused and changing – with Modernising Medical Careers and various other things.

We should debate it, maybe here or in a conference; but perhaps also widen the debate slightly and look beyond the GMC’s role specifically. I think that we have a contribution to make to this area, which I am not happy that we have altogether got our heads round.

THE PRESIDENT: It is back to the point that Bob raised: what does co-ordinating mean? In a sense, we could allow it to mean almost anything we want it to mean. It is a helpful catch-all.

PROFESSOR PETER RUBIN: These are very helpful observations. I have already answered Bob’s point about the postgraduate elements of this. I agree with what has been said about that. It would be very useful to get a clarification from all concerned on what everyone who is involved in this thinks they are doing, and what legal power they think they have in order to do it. It would be very useful and possibly very illuminating.

Turning to the point made by Bob Shaw about admissions – we are not looking to debate issues this afternoon or to raise issues about the merits or otherwise – what we had in mind there was not at all related to the widening-access agenda that is being promoted by the funding councils and the Government. This is more to do with whether the right people are coming into
medicine. It is a very challenging issue but a fundamentally important one in terms of our role to protect the public. It was really asking whether we should be exploring whether we should be more prescriptive in the guidance we give to universities about their selection procedures and about how they monitor their selection procedures. That is the kind of thing we had in mind there.

The point you make, President, is a very helpful one. There is no doubt that having some protected time, where you hammer out one issue and not be worried about the next agenda item that is coming up, is extremely useful. As you say, if we did have something like this at the Council meetings – it does not need to be education each time obviously – there are some major issues that would be helped by some more free time to talk them through. If it were the wish of Council for us to bring education items to such a forum, we would be very happy to do that.

I absolutely agree with Jim’s point about students. As many of you will know, I have spent much of the last umpteen weeks doing road shows around the UK on the issue of modernising the pre-registration year – something I presented to you a couple of Council meetings ago. There has been a very strong attendance from students and pre-registration house officers, and it has been really valuable. Their perspective is quite different; the views expressed are well thought out; and it has been a tremendous help to have them there. So I would be strongly in favour of that – and also the European dimension.

I agree with the point about not making this rigid. We need to have some structure to the conference, so that people know what to expect, so that we can invite speakers, and so on; but it needs to be something where people can have a fairly free-flowing debate.

THE PRESIDENT: Can I take it that Council gives its approval to this proposal? Are we happy that Peter takes this away and works up a conference? [Agreed]

Can I take it also that you would like to explore the possibility of having some kind of seminar arrangement linked to Council meetings? We did discuss it once before. Perhaps we might ask Andrew to look at that. It depends on the pressure of work, of course, but as a concept – that we took an educational issue from time to time and looked at it – does that meet with your approval? [Agreed]

MR STEPHEN BREAMLEY: So long as it is understood that it is not a meeting of the Council and we do not have to have a transcript.

THE PRESIDENT: That was the sense in which I was floating it.
GENERAL MEDICAL COUNCIL

COUNCIL

Wednesday 7 July 2004

4b Disclosure Policy: Fitness to Practise History

THE PRESIDENT: Paper 4b deals with the disclosure policy and the second paper with Fitness to Practise changes.

MS UNA LANE: I should probably begin with something of an apology for the length of the paper and the sheer number of recommendations, a to i, which run to two pages. That is nine recommendations that the Council needs to consider. However, I think it is fair to say that this is quite a complex issue. I hope that, if I take you through the background and the initial discussion part, that will hopefully make the recommendations from the Fitness to Practise Committee a little clearer. It is a complex issue so, if I lose the thread at any point, I am sure that FPC members will point me in the right direction.

This paper concerns information that the GMC holds about a doctor's Fitness to Practise history where the case has been concluded and there are no current sanctions. You will see in paragraph 4 that we are developing policy in relation to current complaints or concerns. We discussed that in relation to paper 4a when we were looking at the draft rules. Council already has a clear policy in relation to current sanctions on registration, which are erasure, suspension and conditions, which is that we disclose those sanctions to all enquirers apart from those conditions that relate to a doctor's health. The focus of this paper is concluded cases where there are no current sanctions on registration.

To go back briefly to a history of this matter, when Council considered the issue in November 2003 and agreed its position in relation to current complaints, members agreed at that point that issues in relation to Fitness to Practise history were extremely complex and that Council's view on that issue should perhaps be developed in conjunction with other interested parties. To that end we agreed a consultation process to involve a number of seminar/workshops as well as a formal consultation process and consultation document. The Chair of FPC, Dr Trowell, chaired a number of those workshops in February in both London and Manchester. I believe that quite a number of Council members attended those seminars and that they were useful and helpful. We used those workshops and the comments made at them to mould the consultation paper that we drafted for the formal consultation process. I think it is fair to say that there was quite a strong feeling across the board at those workshops that it should be the GMC's aim to be as transparent as possible in terms of the information that it provides to enquirers.

The formal consultation process lasted for two months, through March and April, and we spent quite a lot of time going through the responses in May. I think it is fair to say that the specific issues fell into five main areas, and we have tried to capture those as best we can in paragraph 13 on page 4 of the paper. In a moment I shall take you through each of those in some detail in respect of the specific recommendations, but as a reminder I shall give you an overview of them.

There are clearly situations where there have been restrictions on registration but they are no longer in force. There are situations where there have been findings of serious professional misconduct before a PCC but no restrictions were imposed by the committee. There are situations where the doctor has appeared before a PCC or a CPP but was found not guilty. In future procedures which 13d relates to there is the potential for the issuing of a warning. We shall come to that in a moment; we touched on it when we dealt with paper 4a. There are
situations where a complaint or other concern has been closed at a very early, or a fairly early, stage in the process.

FPC considered the responses to the consultation. The proposals and conclusions that FPC reached are set out in this paper. I think it is fair to say that this is a complex area, and FPC was mindful of the fact that we need to bear in mind the rights and interests of patients and balance those against the rights and interests of the doctor. I think the challenge in developing a policy is that it reflects the GMC’s duty to protect patients while ensuring that doctors are fairly treated in respect of the historical information that we hold.

Three relevant questions emerged from the consultation, which are set out in paragraphs 23, 24 and 25 on page 6. The first key issue is whether the information is already in the public domain. You will know that PCC and CPP determinations are published on the GMC website and the PCC meets in public. The second issue is whether there has been a finding by a committee of either seriously professional misconduct or seriously deficient performance. The third issue is whether there has been any findings of fact in relation to the allegations where those findings fell short of either seriously professional misconduct or seriously deficient performance.

The first two recommendations concern trying to set the framework in terms of general principles. In recommendation 2a the Committee is proposing that, as a general principle, where information is already in the public domain and there has been a finding by the GMC, the historical information should remain a matter of public record indefinitely and be disclosed to any subsequent enquirer. FPC was agreed that there probably should be some qualifications to that, which we shall come on to in a moment. I think the first recommendation speaks for itself and is that, as a general principle, all historical information that has already been placed in the public domain should be disclosed to any enquirer.

THE PRESIDENT: Are people content with that? Do you want to discuss it?

DR KRISHNA KORLIPARA: Because this forms the framework for what follows, I am slightly uncomfortable with this all-inclusive term “all historical information”, regardless of the finding, which includes a finding that no charge has been proved. I think it would be against the reasonable rights of any doctor to place in the public domain beyond a certain time limit the fact that he appeared before a GMC committee when no guilt was proven. People might think that that would do no harm, but the very fact that information about a doctor goes on record where no guilt has been proven might itself be seen as a black mark and also as some sort of a trigger for other kinds of suspicious observations of the doctor’s behaviour.

THE PRESIDENT: Is that in any way taken up in 2e, Krishna?

DR KRISHNA KORLIPARA: It is taken up but, because it is a framework for what follows, I thought I would flag it up.

THE PRESIDENT: Una, that must be right, in some sense?

DR JOAN TROWELL: When we were drafting these recommendations, Una and I did a small experiment, which was to do a number of Google searches, looking on the Internet for
the names of individuals whom we knew had no current sanctions against them. We did not receive any hits to the GMC website but, not surprisingly, with all of the names we had hits on other websites. Once information is in the public domain, the GMC has no control of that data. The recommendation is drafted in that way because, if someone has done a Google search and has found on a local newspaper website, for example, the fact that a doctor is being investigated, in a case where that doctor has been acquitted, it is in the doctor's interests for that point to be made quite clear. We cannot control information once it is in the public domain. I would recommend that others try a similar experiment, because it was very revealing.

DR KRISHNA KORLIPARA: I think that completely neutralises my argument.

THE PRESIDENT: Are we generally content with recommendation 2a? [Members: Yes.] I think we may not be able to agree it at the moment because we are not quorate. Stephen is upstairs at the moment. I will rehearse it when he comes back, rather than delay matters. We will just keep going.

Will you take us on to 2b, Una?

MS UNA LANE: Recommendation 2b is effectively the flip side of the coin in terms of general principles and setting and framework for further discussions throughout the paper. The recommendation is that historical information that has not been placed in the public domain will only be disclosed in limited, defined circumstances. It is the flip side of the coin to the first recommendation.

THE PRESIDENT: Are we content with that? [Members: Yes]

MS UNA LANE: Recommendation 2c really gets into the nitty-gritty of the consultation document itself. It relates to sanctions which have affected a doctor's registration but are no longer in force. The question we asked was whether or not they should remain a matter of public record indefinitely and continue to be disclosed to any enquirer. They are currently a matter of public record indefinitely and we do disclose them to any enquirer in response to a specific request. I think it is fair to say that there was general agreement both at the workshops and in response to the consultation that we should continue to do that. For example, there is a quote from the Department of Health at paragraph 38 which clearly suggests that this is information that is relevant to any subsequent employer and should be disclosed. There was a minority of respondents to the consultation document who argued that perhaps we should continue adopting a spent-convictions approach or that perhaps we should consider a time limit for the disclosure, the suggestion being that that time limit should be five years. However, having considered the responses to the consultation, and having attended many workshops, FPC members concluded that past sanctions should be disclosed to any enquirer while the doctor remained on the Register.

THE PRESIDENT: In some ways this is harsh justice, but it is probably a recommendation that is difficult to resist at this time. Does anyone feel strongly that we should oppose it?
MR BOB NICHOLLS: I quite agree that the information should be made available, provided it is made available in a format that shows that the process is now completed and that there are no longer restrictions on that doctor’s practice. If the question is just “Were there any restrictions placed?” and the answer is “Yes”, that might be misconstrued by whoever receives that information. I feel the question has to be very vociferously answered “Yes, but no longer” or “Yes, but not for X number of years now”.

THE PRESIDENT: Can we give that reassurance?

MS UNA LANE: Yes, we can. This paper is about principles. We need to work with the Fitness to Practise Committee on how we put these principles into operation. We shall certainly take that on board.

THE PRESIDENT: Are there any other comments on 2c? Are we content with recommendation 2c? [Agreed]

Ruth, while you were out of the room, we were content on recommendations 2a and 2b in paper 4b but we were not quorate.

MS RUTH EVANS: I am so sorry; I was actually working.

THE PRESIDENT: I was not suggesting otherwise. This is a technicality.

THE VERY REV GRAHAM FORBES: The question is, are you content?

MS RUTH EVANS: Yes.

THE PRESIDENT: You are content on 2a and 2b. [Recommendations 2a and 2b agreed]. We have agreed 2c and now come to 2d.

MS UNA LANE: Recommendation 2d is related in many ways to 2c. There are situations where the Professional Conduct Committee will make a finding of serious professional misconduct but will not impose a sanction. You will see in the note above paragraph 41 that, if the CPP finds seriously deficient performance, it must impose a sanction. There will be situations where the PCC makes a finding of seriously professional misconduct but does not impose a sanction. Clearly the question is whether or not that finding should be disclosed in the same way that sanctions are disclosed indefinitely whilst the doctor remains on the Register.

FPC’s recommendation is at 2d and is that all such findings should be treated in the same way as those that resulted in sanctions on registration and should remain a matter of public record indefinitely and disclosed to any enquirer.
DR SATHIYAKEERTHY ARIYANAYAGAM: I have a point for clarification. Una, you referred to a finding of serious professional misconduct by a PCC but no sanction being imposed. Is it implied that the word "sanction" excludes admonishment? I had understood it the other way.

MS UNA LANE: This relates to situations where there was no formal sanction that affected registration.

THE PRESIDENT: Are people generally content with recommendation 2d? [Agreed]

MS UNA LANE: Recommendation 2e is where matters become complicated, if they have not been complex enough already. The paragraphs in relation to this recommendation begin at paragraph 46. We looked at two specific areas, and these probably link with the next two recommendations. There will be situations where there will be findings of fact in relation to an allegation or allegations before the PCC but where such findings do not amount to serious professional misconduct. There will be other situations where there will be no findings of fact or findings in relation to the allegations.

The first recommendation relates to the first circumstance, where there have been findings in relation to the allegations but they were not sufficiently serious to amount to serious professional misconduct. The issue, of course, is whether or not we disclose that information to subsequent enquirers, as we do where sanctions have been imposed or were there were findings of serious professional misconduct. I think it is fair to say that when this was discussed at FPC there was a range of views as to how the Council should approach this in terms of its policy. Therefore the recommendation at 2d is not a "to agree" recommendation but a "to consider" recommendation.

The debate that took place at FPC is set out at paragraphs 53 to 57. I am sure that some members may want to comment further. It is fair to say that the discussion was fairly finely balanced. Some members had reservations about disclosing any information on what was effectively a "not guilty" finding, while others felt that the information was already in the public domain. Other members tended to be swayed by the fact that it is very difficult for the GMC to control information once it is in the public domain. Joan commented on that matter earlier. A policy was not finally agreed by FPC and the Committee considered that we should put the matter to the Council for discussion.

THE PRESIDENT: I guess that there will be a variety of views around this table, as well. The issue is a tricky one for all of us. If the facts have been proved but there has been no finding of serious professional misconduct or seriously deficient performance, how do we quietly forget about them?

DR BRIAN KEIGHLEY: What concerns me is balance. Findings of fact are recorded but facts which might tend to exonerate a doctor are generally not so assiduously recorded. If someone was charged with failing to visit a patient and the case went through a hearing, it might come out in evidence that it was entirely reasonable that the doctor in certain circumstances did not visit a patient. It would be recorded as a matter of fact that a patient was not visited, but the balance of exoneration would not be published.
THE VERY REV GRAHAM FORBES: I think we now have a new criterion, the Google search criterion. If we use that criterion, we then have "It will be in the public domain. "In the public domain" needs to be coupled with an explanatory gloss expanding on what these things mean. I think that that would redress the balance. The obverse would be to say that all our past phrases such as "transparency" are out of the window, and that must be wrong.

THE PRESIDENT: The only way round that is to give the entire judgment when someone asks a question on fact, putting it into context rather than simply answering "Yes" on the fact.

THE VERY REV GRAHAM FORBES: Strictly speaking, some of the findings of fact are you are a GP and you live in Balfron.

THE PRESIDENT: I understand that.

PROFESSOR CHRISTOPHER BULSTRODE: One of the frustrations of doing medical negligence work is that time after time you see the same problem coming through: the facts being proven and the case either being settled out of court or not proven. I think the GMC should be looking for patterns of behaviour, not just single episodes. Without the ability to chase those patterns, we shall be hampered in our ability to regulate.

THE PRESIDENT: I was trying to think of a way in which we could provide the relevant information and put it into a context that was more meaningful. That is what I been trying to grasp at here, totally ineffectively.

DR RACHEL ANGUS: I am not in favour of the Google search test. Anybody can do a Google search, but people who are concerned about doctors phone the GMC. I think one gets quite a different type of information from searching the websites of local newspapers. Although it is an interesting thing to do, and the information is in the public domain, I think that our responsibility is quite different.

THE PRESIDENT: I understand that. Presumably we would seek to have some sort of match on the facts. It would be tedious if facts came up that we were in some way denying when we actually knew them.

DR RACHEL ANGUS: Yes. If facts are proven, I have no problem with that being disclosed by the GMC. My concern is where facts are not proven, even though they may be on the local newspaper websites, because they tend to report when a case first starts.

THE PRESIDENT: Recommendation 2e relates to proven facts.
DR RACHEL ANGUS: Yes, I am sorry, I am jumping ahead.

MR FINLAY SCOTT: To complete that clarification, the phrase "relevant to the allegations" is intended to deal with the point that Graham made. The fact that you were a GP in Greenock is not a fact relevant to the allegation; it is the detailed charges that follow from that stem that are the issue.

PROFESSOR SAVAGE: I would support this because of the Google-test point, but I should like us to put the information into context. For example, if in Brian's suggested case the reason that the doctor had not visited a patient was because he himself was in hospital, then the GMC should be able to say that it was correct that he did not visit the patient but that there was an explanation which exonerated him and that is why it was not found to be SPM.

THE PRESIDENT: Yes, it needs to be put in some kind of context.

MR FINLAY SCOTT: I am sure that in principle that must be correct, but I think we have to be careful not to create something that is impossible to deliver in practice one hundred percent of the time. The reality is that we get about a thousand registration enquiries a day. We absolutely agree with the principle that everything should be in context, but, if the Council concludes that this information should be in the public domain, we need to think about how to operationalise that, because I think there might be a challenge in some circumstances.

PROFESSOR WENDY SAVAGE: I know we get a thousand enquiries a day, but doctors on whom findings of fact have been made but have not been found guilty of SPM are a handful a year. I do not think it would be all that difficult to operate.

THE PRESIDENT: What Finlay is saying is that, if we accept the recommendation, they will operationalise it. On that basis, are we content with recommendation 2e?

MRS FIONA PEEL: I think we have to keep the principle very clear that this framework deals with findings of fact; we must not get opinion into this framework. We must remember that we are here to protect patients. If we have those principles, that will limit how we deal with it. We must remember when we are putting together guidance that those are the overriding ways that we do it.

THE PRESIDENT: Do you accept Brian's point that there may be individual facts that in some ways do not give a proper overview of the problem?

MRS FIONA PEEL: Yes, I do agree with that; but, if you are always trying to balance it, you
have to be careful that you do not go into opinion, because it would be wrong to do that in this particular case.

**THE PRESIDENT:** Am I right in thinking that in all these cases there would be a determination? [Several members: Yes.]

**MRS FIONA PEEL:** We are asked for a finding of fact. It must be very clearly fact in this particular recommendation.

**THE PRESIDENT:** I do not want to do Finlay’s job for him, but one way forward might be to release the determination.

**SIR MICHAEL BUCKLEY:** What we must do is to release something that gives a true impression. You may make perfectly true statements but, if they are not accompanied by other true statements, they can in fact be defamatory. I am just reinforcing the principle. Yes, we should release the facts but we must make sure that what we release gives a true impression of what actually happened.

**MR BOB NICHOLLS:** In future we shall have a way of operationalising without pain but giving the balance we are looking for, because we are now required to record decisions; historically we were not so good at recording decisions. I agree with Fiona. With cases that happened 20 years ago we are in danger of having to come up with opinions, and that would be highly dangerous. I think that the operationalisation is not quite as easy as Wendy made out. It might be easy in the future, but it is not easy not looking back. I think the principle is clear but I believe that it is not easy retrospectively to achieve the balance that people are seeking.

**THE PRESIDENT:** Are we content with the principle in recommendation 2e, letting others see how best this can be operationalised? [Agreed]

**MS UNA LANE:** I do not intend to say much on recommendation 2f, which is directly related to the discussion that members have just had. This refers to situations where there are "not guilty" findings and no findings of fact relevant to the allegation. FPC proposes that these cases should generally not be disclosed to any enquirers but should be disclosed in limited, defined circumstances where there are public-interest reasons for doing so.

**DR KRISHNA KORLIPARA:** I find this strangely inconsistent with the preceding paragraphs. We have talked about the Google test and the fact that information is in the public domain and there being no reason for our not disclosing it, but in this recommendation we are saying that we shall not disclose these cases to the public. It sits oddly with what we have been discussing previously.
THE PRESIDENT: The recommendation is "... where there were no findings of fact ... should not generally be disclosed." Why is it inconsistent?

PROFESSOR WENDY SAVAGE: It is inconsistent because we are saying that it is in the public domain that someone has been before the Professional Conduct Committee, it may have been all over the local newspaper, and therefore we should disclose it. Is this what we agreed in FPC? It is logically inconsistent with what we have said in the previous items.

THE PRESIDENT: Presumably it is the unsubstantiated allegation point, is it not? Somebody makes a complaint, there are no findings of fact, nothing happens to the doctor, and a smear remains.

PROFESSOR WENDY SAVAGE: Unless we say, "No, we did not find any of the facts proved, we did not impose a sanction", that smear will remain on the doctor because he is recorded in the newspapers as having been before the GMC.

MR FINLAY SCOTT: The newspaper reports the matter at the time, there is an outcome, and clearly that is in the public domain, but what is being posited here is the situation 15 years afterwards. After a significant time interval, 15 years after a PCC hearing which found no facts proven against a doctor, should we be disclosing the fact that the doctor appeared before the Professional Conduct Committee?

DR BRIAN KEIGHLEY: I am thinking of this in practical terms. Someone from the Daily Express phones up and says, "I'm investigating this doctor. I hear a rumour that he was in front of you in 1966. Is that true?" Do we say, "No"? That is hardly transparent, and it fails the Google test. I know what this recommendation is trying to achieve, but it is unsustainable if you actually have to utter a negative in reply to a question when we know the answer is "Yes".

THE PRESIDENT: The potential solution to this problem is the same as the solution to the last one, which is that you operationalise it as best you can and give as much in the way of factual context as you can.

DR SATHIYAKEERTHY ARIYANAYAGAM: I go back to what Krishna said. It is perhaps pertinent to ask the question in relation to this paragraph, "Disclose what?" Do we disclose the fact that I appeared before you, why I appeared before you, or what the outcome was? The outcome might have been nil. The fact that I appeared before you is in the public domain; it is on Google. You cannot do anything about it. I think this is inconsistent with what we have already discussed.

THE PRESIDENT: Is there a general view that this information ought to be released with the same kind of in-context arrangements that we had for the previous recommendation? [Several members: Yes.]
DR BRIAN KEIGHLEY: But only to enquirers.

THE PRESIDENT: Yes, but only to enquirers. Is that a general view? [Several members: Yes.]

DR BRIAN KEIGHLEY: There is a caveat. What we should not be required to do is to supply the information when someone is on a fishing expedition and says, "I want to know all the cases you saw in 1966."

MR FINLAY SCOTT: I am sorry, but I do not think that that is a realistic position to take. PCC hearings are in the public domain; the minutes are in the public domain; they are part of the historical sequence of hearings. We regularly have journalists coming to 178 Great Portland Street precisely for that purpose. I understand why Brian has said what he said, but in practical terms, and even in philosophical terms, I do not think that that is deliverable.

My own view, for what it is worth, is that someone who sets out to investigate the background of an individual doctor has to be given that information. Whether it happened 20 years ago or 30 years ago, it is public-domain information. I do not see how we can deny that. The distinction drawn was "In response to enquirers", i.e. "Is there anything wrong with this doctor's registration?". The answer is, "No", and you stop at that. The answer must depend on how the question is posed, otherwise we should face an impossible task operationally.

MR PAUL PHILIP: Clearly, we have quite a lot of work to do to on the operational implications of this. It will be significant. David Bean is not here today. I think it would be doing him a disservice to say that he had significant reservations about this recommendation at the Fitness to Practise Committee. His voice would probably be the loudest in suggesting that the recommendation before the Committee, which has now been slightly reworded, should be agreed. The fact that a PCC is held in public and therefore on the record does not necessarily mean that you would always disclose that information if the only facts found proven were the doctor's name and his address. We felt that that was probably unreasonable and pushing at the bounds of human-rights issues.

THE PRESIDENT: I think that, if I were the doctor, if somebody were thinking of making an allegation, I would rather they did know that the only allegations found proved were my name and address.

MR PAUL PHILIP: That was the contrary argument.

THE PRESIDENT: We have to come to a decision on this. It seems to me that we are very close to consensus, minus David Bean, that this ought to be operationalised, as the other one was, put into context with the determination, if that is possible, and not hidden. [Some members: Delete "not"].
MR FINLAY SCOTT: The suggestion is that we delete "not" in the third line of the recommendation so that it reads "should generally be disclosed to enquirers". We should have to delete the end of the recommendation.

DR JOAN TROWELL: I wanted to make a practical point in relation to the operationalisation. As part of the consultation, the defence unions came up with some quite helpful suggestions. We might well take this sort of issue forward in partnership with them so that we know that what we are doing will not upset them.

THE PRESIDENT: That is a good idea.

DR JOAN TROWELL: I think that the form of words and the way in which the context is given will make or break the success of this. I have no problem about being completely open, if that is what Council wants, but I think it is important that we do not lay ourselves open to a lot of subsequent charges as a result of it.

DR RACHEL ANGUS: I am a little concerned that "no findings of fact" remains on your record to be declared to any telephone enquiry.

THE PRESIDENT: It remains in the public domain. It is on your record; it is there; it is a fact.

DR RACHEL ANGUS: I understand that it is in the public domain, but the issue we are discussing is disclosure to any enquirer.

DR FINLAY SCOTT: I wonder if I can help? Once you reverse the presumption and delete the "not", it then becomes "disclose to enquirers" rather than "any enquirer". We envisage a hierarchy of questions: "Is the doctor registered?" "Yes." "Are there any restrictions on his registration?" "No." "Has he ever appeared before the Professional Conduct Committee?" "Yes." You would not work your way down that chain unless the questions were posed. A thousand registration enquiries a day are received; 999 of them stop with "Is the doctor registered?" "Yes." The phone goes down, and that is the end of it. One envisages a hierarchy of questions to which we would respond appropriately. We would not volunteer this information "to any enquirer".

THE PRESIDENT: In a technical sense we are rejecting recommendation f. We are deleting the word "not". [Some members: And deleting "any".] We are also deleting the word "any". Are people content? [Agreed]

MS UNA LANE: I hope the last three recommendations will be less controversial. The last
three recommendations relate to future procedures and specifically to Fitness to Practise history in terms of future, if that is not a contradiction in terms. As we discussed in relation to paper 4a, warnings will be issued under the new Fitness to Practise procedures potentially at both the investigation stage and at the adjudication stage. Members need to consider how and where we should disclose information about a warning that a doctor has received. The relevant paragraphs are paragraph 61 and following.

The first recommendation, recommendation g, concerns the period of time during which the warning remains on a doctor's record for the purposes of revalidation. It has already been agreed that that period of time should be five years. It was always envisaged that a doctor's employer would be informed of a warning at the point when the warning was issued. The recommendation now suggests that any prospective employer who makes an enquiry during that five-year period should be informed of the fact that a warning has been issued to the doctor while the warning remains in force.

THE PRESIDENT: I essence, this is what we agreed previously, I think.

PROFESSOR CHRISTOPHER BULSTRODE: Have I misunderstood this? Does not our change in recommendation 2f make all this redundant? Anyone who makes an enquiry will be told at any time in the future what the outcome was.

MS UNA LANE: I am not sure that that is necessarily the case. I think we were talking about information that was already in the public domain.

THE PRESIDENT: Yes, but, if I take the gist of what you were saying, Chris, you are not opposed to this recommendation.

DR SATHIYAKEERTHY ARIYANAYAGAM: Going back to the Google test, the warning might be found there.

THE PRESIDENT: Let us take it as it is. Is there any dissent from 2g as it currently stands, i.e. that a warning would be disclosed to prospective employers?

PROFESSOR MIKE PRINGLE: Can I question the five-year period and the logic for choosing it? I think there is a certain logic in saying that, if a doctor has ever had a warning, a prospective employer should be told about it.

THE PRESIDENT: I think that that is encompassed in 2h, is it not? I think the five years is simply related to the revalidation five-year cycle; there is nothing particularly scientific about it. It was debated in Council some years ago. It could easily be changed. That was the relevance of the five years, I think. Recommendation 2h indicates that we might not be getting rid of it completely.

Are we content with recommendation 2g? [Agreed]
We move straight on to **recommendation 2h**, which says that we should wait and see before we make a decision. It does not seem very radical.

**DR BRIAN KEIGHLEY:** If a doctor does not know whether a warning will stay on the record for ever and a day, that might affect whether the doctor accepts a warning or contests it in an oral hearing.

**THE PRESIDENT:** I think doctors will nowadays have to be aware that that which they do may well stay with them during their professional careers. I think that anyone not working to that understanding is making a mistake. I am in your hands. My feeling would be that we should agree 2h and review it later, but I am happy to take alternative views. Are you content? It is not making a decision.

**DR BRIAN KEIGHLEY:** The recommendation is that we postpone, but I think we should include in it that we should consult.

**THE PRESIDENT:** Can we agree to take recommendation 2h forward and to come back with a more concrete proposal in due course, i.e. within a reasonable period of time? [Agreed]

Is **recommendation 2i** non-contentious?

**DR ALEX FREEMAN:** In the first section of the paper it is said that it is assumed that any information about a doctor who has come to the attention of the GMC because of health will not be disclosed. However, there are some arguments for saying that it may well be in the interests of either the public or the doctor for that information to be disclosed to enquirers. I wondered if there were any thoughts about what we should do about information about health, whether it be current or historical, given that Shipman was brought to the GMC's attention originally because of health reasons. There may well be a strong public-interest argument for saying that historical data should be disclosed.

**THE PRESIDENT:** Do you want to respond to that, Paul?

**MR PAUL PHILIP:** We have a review ongoing at the moment. I think perhaps we ought to leave it to the review to think about how we deal with that information. There is always the possibility of disclosing the information where it is in the public interest, but, as people might have heard during the confidentiality seminar last night, there is always the issue of balancing the rights of the individual and the rights of society, and it is always a judgment call. Perhaps we might, through the review, take the opportunity to develop some guidance.

**THE PRESIDENT:** Are people content with paper 4b? [Agreed]
GENERAL MEDICAL COUNCIL

COUNCIL

Tuesday 25 January 2005

6. Strategy and Planning

6a. The Shipman Inquiry: the Fifth Report

THE PRESIDENT: Item 6 deals with the aftermath and the way in which we are going to approach the fifth report from the Shipman Inquiry. It is a series of papers, all of which are critically important.

Taken together, they represent our first substantive response to the inquiry and they are based firmly on our current statutory role. At the same time, as I indicated before, we need to have a reasonably broad remit and we need to encompass the lessons from the other inquiries that have reported – the Neale and Ayling inquiries. So I think that the focus needs to be on the effectiveness of the regulatory system as a whole, not just focusing narrowly on our own responsibilities.

We ought to make as much progress as we possibly can, ensuring that we do not cut across any of the recommendations or remits for the CMO’s review; but we need to build on the progress that we have already made.

If I talk about paper 6a to begin with, the paper has pointed out one or two errors in the report. As you would expect, we are undertaking a full analysis of the report itself and we are keeping the inquiry fully informed of what we are doing. These reports will of course come back to Council, as we get them organised.

Earlier this morning, I indicated the CMO’s review and its remit. That is discussed and described in the first ten paragraphs of paper 6a. Paragraphs 11 to 17 discuss the Government’s response to the fourth report, and that comes up in a subsequent paper for this Council.

The remainder of paper 6a provides an overview of the fifth report and builds on the discussions we have had prior to its release and subsequently, during the internal conference. The way in which we intend to approach that report is detailed in paragraphs 19 to 22 and, in particular, paragraph 22 of the paper indicates the way in which we hope to take the discussions forward.

I am happy to take comments on the first 22 paragraphs, but they lead inevitably to the recommendation 2a, to endorse the approach we should take to the fifth report, as described in this paper. Are people content that this is a general approach to the issue?

Let me add a few comments to that. When we looked at the papers that went out in the summer for consultation, building on the policy work that was done for revalidation, there were areas that we ourselves acknowledged required further work. Let me remind you of what these were. Our own quality assurance arrangements – how we are going to ensure that this is a process that is effectively and robustly implemented – have yet to be fully defined. I think that it would be very helpful if we moved quite rapidly in looking further at that quality assurance process.

Second, we have said quite explicitly, in evidence to the inquiry and subsequently, that the purpose of revalidation is not to weed out poorly performing doctors. Nevertheless, we have a responsibility for working with others to do precisely that, and I do think that we want to have a clearer view about what our role is in doing that. I think that the view of Council in the
past has been that we cannot and should not attempt to do that on our own, but clearly we have an important role to play with others. I think that we might want to address that as well.

Third, the CMO’s review is bound to look at the way in which our functions integrate with appraisal and clinical governance. It would be enormously helpful if we had a view from this Council as to how we would see that best taken forward.

If we join these three things together – our own quality assurance arrangements, how do we participate in identifying and dealing with poorly performing doctors, and how do we best see the integration between our own functions, clinical governance and appraisal – I wonder if it would not be sensible for us to have a seminar or internal conference some time within the next few weeks, so that we can hone our own ideas and feed effectively into the CMO’s review, and make sure that we are all speaking together on these three issues. That is not in any sense to change what we have previously agreed – although of course, as in any organisation, we can do that if we wish – but rather to build on the consultation paper we shall be discussing later, and the broad level of support that obtained, but nevertheless to get clarity on some of these issues that we ourselves have already flagged up as requiring greater concentration from this Council at some time in the future.

The proposal from me, therefore, is, if you endorse recommendation 2a, can we add a rider to it that we will organise an internal conference some time within the next few weeks to take forward these three specific issues?

MR BOB NICHOLLS: You have anticipated what I was going to say, President. First, I want to say that I think this paper is excellent. It gets us on to the front foot. It indicates that we are not complacent and we are learning; but it also challenges, where we need to challenge. The office has done an outstanding job in a short time, and with a moving target.

However, I do think that we need to reflect. In view of other events going on in the wider quality assurance framework of the country, with which I am closely associated, I think it essential that we have the sort of event you are suggesting, and to gather intelligence on what else is going on.

If, as the paper keeps emphasising and as we have emphasised over recent years, we are part and not the whole of this, then we need to know what is going on elsewhere – and I am quite alarmed about what is going on elsewhere – which may mean that we have to do other things. The linking of our internal consistencies – size of Council versus the functions that the Council will have – with the external world in which we will be playing a part is absolutely vital, before we finalise our contribution to the review. I therefore fully endorse your suggestions and I am very willing, with that rider, to support recommendation 2a.

THE PRESIDENT: There may well be a need to look at the issues that you raise, and the governance issues and the adjudication issue as well. However, my suggestion was that we focus more directly on those particular issues that I mentioned. Are you content with that? That is not to say that these other issues you have raised are not important: they clearly are.

PROFESSOR MIKE PRINGLE: I want to endorse your suggestion of a seminar, President, but I want to make some remarks about this section of the report and this particular report in general, if I may.

The first thing to say is that my opinion – and it may not be widely shared – is that the events that happened following the last internal conference of the Council are probably the most serious events that have happened for the GMC in many a long year.
The fact that control and decision-making around revalidation – our flagship enterprise that we have been working on for many years – have now been taken away and located within the Department of Health is, in itself, a serious indictment of the General Medical Council and of the process that we were putting in place. The fact that that has now called into question all our reforms, all the decisions we made, and all the work we have done in trying to create a new, modern General Medical Council, seems to me to be highly regrettable and the worst possible outcome that we could have had from the Shipman Inquiry.

I am therefore deeply concerned about the state of affairs that we find ourselves in at the moment, and I see no reflection of that concern in the paperwork before us. Indeed, the paperwork says, “We welcome the inquiry” – we welcome therefore an inquiry into the fact that we have not delivered a method of revalidation that is fit for purpose.

It seems to me, therefore, that the problem we face at the moment does stem from the decisions made around revalidation. If we had had a system for revalidation that was fit for purpose, then I do not think that we would have the internal inquiry within the Department of Health and I think that we would still be very much in control of our destiny. We therefore have to ask how did we get ourselves into a situation in which we have lost control of revalidation, and where we have put forward a scheme for revalidation which Dame Janet has declared, quite robustly, is not fit for purpose.

If you read the Shipman Report – and I hope that everybody has read chapter 26 in detail – it is quite clear that Dame Janet believes there was a change of philosophy; that there was a pragmatic change which was reflected in a change in the principles underlying revalidation. I think that, in the spirit of the request stated in this paper – which is to demonstrate our determination to learn from the past – I believe that we have to understand very clearly what happened in relation to the change of view which took place within the GMC, to shift, as I believe, from a system that was fit for purpose to a system that was not.

Dame Janet suggests that the BMA had a heavy hand in that, and that actually it was the consultants in the BMA who forced the hand of the GMC. I have asked for notes of any meetings that took place at the relevant period. I have been assured that there were no such meetings, and that therefore it was not the work of the BMA. It may be that there were meetings that were not minuted, but of course we will not know about those.

If it is an internal decision, then it means that within the GMC itself a decision was made to change the form of revalidation in order to make sure that it was pragmatic, but which undermined the principles and meant that it was not fit for purpose.

I believe that we need to know what did happen, how that decision was made, and how the principles of revalidation were changed within this organisation. Until we understand that, it will be very difficult for us to respond effectively to the CMO’s review. If we continue to go into it, as the President just suggested, believing that the purpose of revalidation is not to do with fitness to practise, then we will end up by having a system foisted on us which we do not agree with, and I think that therefore would be the end of the GMC as we understand it and know it.

I therefore believe that we now have a unique opportunity to reflect on the past, as this paper says in paragraph 22(c), to understand what happened and the way it happened, and to try to make sure that it never happens again. I would ask that we do that inquiry.

THE PRESIDENT: I missed the last bit, Mike. I was not quite sure what you were asking for. Could you say it again?

PROFESSOR MIKE PRINGLE: I think that we need to understand what happened when the fundamental change to revalidation happened; to understand how it happened, why it
happened, who was involved in that decision, and therefore to understand where the whole process went wrong – so that we can try and recover the situation.

**THE PRESIDENT:** Yes, I am sure that is right. The view might be – and I am very happy that we look at all the documents – that there has not been a substantive shift. I understand that is precisely what Dame Janet says, but I think that one of the issues the CMO’s review will pick up is whether there has or has not been.

I have here a note from a Council paper, dated 3 to 4 November 1998, and a recommendation 2a. This is about revalidation of specialists and generalist registration. It says,

“Specialists and general practitioners must be able to demonstrate on a regular basis that they are keeping themselves up to date and remain fit to practise in their chosen field”.

These are words that are not different today from then. So there may be a conspiracy theory and, if there is, we should look at it; but I am not sure what you say is true. My view is that we should go into the CMO’s review, prepared to show whatever is required.

**DR EDWIN BORMAN:** I am responding partly because, while I am a Council member and I was rather intimately involved in the discussions regarding revalidation – and indeed was rather sceptical of the concept as initially presented – I am also a member of the BMA; I have been a deputy chairman of the consultants’ committee; I was involved in the national negotiations on consultant appraisal; and I was largely instrumental in establishing the link between appraisal and revalidation. I therefore feel that it would be inappropriate for me simply to allow what has just been said to pass.

I am aware of one meeting that I attended – I was attending on behalf of the BMA – at which were present Sir Donald Irvine and a number of other members of the GMC, and I trust that the minutes of that meeting would be made available. If they are not available from the GMC, I trust that the BMA would be able to provide them.

I have to say that I simply do not recognise what Mike Pringle has just described as the discussions and decisions regarding revalidation. I do not recognise – not even in the initial concept – what Mike Pringle has described as the purpose of revalidation, nor indeed the potential mechanisms for that. If any decisions were made as to the scope, the nature, and the purpose of revalidation, they were made openly, at public meetings, by the full Council. Indeed, I recall having been on the wrong end of a number of democratic votes, when I very deliberately tried to alter the nature, purpose and scope of revalidation, and was comprehensively outvoted.

I am quite willing to acknowledge that my views on this have changed. I have done so publicly in the past, and I accept that the position the GMC has taken is one that is appropriate, pragmatic, takes into account the factors that were not present at the time that Sir Donald, rather single-handedly, launched an initiative – namely, all of the local mechanisms available for providing comprehensive information on the nature of practice of individual doctors, at least in the hospital sector. I trust that the general practice side will be providing precisely the same sorts of mechanisms.

It was on that basis that the whole Council took open decisions as to how revalidation would proceed. There has not been a conspiracy. There have not been stitch-ups in closed meetings. The BMA, if anything, has been rather woeful in its ability to influence the course on this one.
DR BRIAN KEIGHLEY: I have not prepared anything and I was a little taken aback to hear what Mike Pringle said. I also subscribe to what Ed has just said.

I was there right at the beginning. I was in the meeting in Great Portland Street when Sir Donald launched the initiative, way back in – was it 1998? I cannot remember – but a long time ago. I think that what we have to remember is not only where we want to get to with revalidation but where we started from.

Here was a good idea; there were different interpretations about how that idea should be delivered; but, at the end, it was the single biggest change to medical regulation since our inception in 1858. To get where we wanted to go, we had to engage three constituencies. We had to engage with the public; we had to engage with the profession; and we had to engage with government, with all its multifarious responsibilities, including service delivery.

I have seen, as we all have, changes in policy as it has developed, but I am quite confident that that has developed through consultation – and open consultation – with those three constituencies; notably to the effect that the CMO who is going to undertake the review of revalidation gave comfort to the Shipman Inquiry as late as November of last year.

I think that we therefore have to go forward with the review. Looking back to how an iterative process has confused at least one member in this room – but I doubt the majority – I think is a mistake. We have to go forward. We have had consultation; we have secured agreement to a fantastic change in our professional regulatory system. Like Ed, I do not recognise the talk of conspiracy and meetings that Mike Pringle describes.

THE PRESIDENT: Nevertheless, much as I prefer looking forward to looking back, there may well be merit in documenting just exactly what did happen here, so that we can see objectively what went forward. Finlay has agreed that we should do that, I think.

Can I be clear on one other point? When we are talking about “losing control”, in a democracy we never do have absolute control over anything. In order to take revalidation forward, it required the Government to put their signature to regulations before we could take this forward from 1 April. It seems to me that, in the light of the concerns raised by the Shipman Inquiry, it was very difficult for them to do so – even if they were so minded. So the idea that there is a review and somebody takes a calm look at this seems to me to be the only sensible way forward – which is why I welcomed it and, as you know, spoke to quite a number of you on that evening of 16 December to get your views on it as well.

MR STEPHEN BREARLEY: I would also like to respond to what Mike Pringle has said, because I have to say that I think he has put forward a very idiosyncratic view, which certainly does not match with my view. In representing our present situation as a disaster, I think that he is giving a very inaccurate picture.

There are three points that I would like to make. The first is that a review of some sort in the aftermath of the Shipman Inquiry was entirely foreseeable, and indeed inevitable. You do not spend years of time and millions of pounds conducting an inquiry of this complexity without there being some mechanism put in place to look at what the review has come up with, and to decide what you are going to do with its recommendations. If you look at the way the previous Shipman reports have been handled, it was quite clear that there would be some group brought together to look at this and to decide what would be the way forward. So the review was no surprise at all.

The review covers a lot more than revalidation. It is a review of the recommendations of the Shipman Inquiry. Revalidation has been mentioned specifically, because it was imminent and
needed to be held back, so that the whole gamut of Shipman recommendations could be looked at. It would be entirely wrong, however, to say that this is a review of revalidation.

So it was inevitable, and the GMC has welcomed it. I was one of the people Graeme spoke to, and I thought it was right to welcome it. I still think that it is the right thing to do. The delay will be worthwhile, if it increases public confidence in the ultimate direction of travel – which may be different to that which we already have proposed, but which may very well be very similar.

The last point I would like to make is that there is a tendency generally to see the fifth Shipman Inquiry report and Dame Janet’s conclusions as being holy writ. Dame Janet is a very distinguished jurist and she has spent a lot of time on this – “What she says must be right”. I think, from what we have heard already this morning, many of us feel that what she says is by no means necessarily right. The paper in front of us points to a number of factual inaccuracies in her report, and a number of conclusions which she has reached which are demonstrably false. So to suggest that what she has concluded must be true is a big fallacy.

A few days before her report came out consultation on the guidance and regulations for revalidation, which we had sent out to a large number of interested parties, closed. The analysis of the responses is not yet complete, but it is quite clear that medical organisations, including the royal colleges, health service organisations, public and patient organisations, are very largely supportive of the direction of travel that we have established – after previous long consultation. It will be surprising if, after all of our work and consultation, the Chief Medical Officer’s review comes up with something markedly different from what we have already put forward.

So I think, Mike, the analysis is wrong. There have not been conspiracies. Revalidation has not been rubbished. The review is not just about revalidation anyway. The review will be worthwhile if it leads to a consensus view on what is the right way forward. It is absolutely the right thing to do, and we should participate in it fully and enthusiastically.

PROFESSOR JAMES DRIFE: Just another confirmation that not all of us see the current times in such apocalyptic terms as Mike does. I had wanted at some point to say what is obvious, but perhaps to say it now. That is, I have been on the Council since 1994 and the entire organisation is unrecognisable from how it was in 1994.

For people who have been on Council for only the last two years, or even the last five years, the extent of the change is very hard to grasp unless you can – as some of us increasingly do – remember how it was. You would emerge from meetings frustrated by clear cabals that were making decisions which were nothing to do with the Council, secrecy, et cetera. It was an unrecognisable Council; an unrecognisable organisation. It is really important for us not to underestimate that change – which has been driven from within.

One of the many things that is slightly disillusioning, for those of us who approach retirement, is the fact that it was the GMC which produced this convulsion itself. It was perhaps foreseen a little too late, as these things often are, but the change was made – and that is why we are where we are today. If that change had not been made, the GMC would no longer exist, and I think that would have been a regrettable thing.

The other thing is that there has been a vast change within the NHS, in a slightly shorter timescale. Looking back at 1994, I was on a trust board in the mid to late 1990s and, clinically, governance did not exist. There was absolutely no mention of quality control of medical practice, or even NHS service. The trust board consisted entirely of discussions about money and political initiatives. That was a change which happened as the GMC was gearing up its first thoughts towards revalidation. Much of that change in clinical governance was driven by the current CMO, as I perceive it. That might not be quite correct, but here we have a CMO who has made a huge change in terms of what the NHS doing and we have a Council which has itself produced reforms, bringing us to where we are today.
In terms of those tectonic plates shifting, to see our discussion degenerating into medical sectarianism – who said what to whom on such-a-such a day in 1998, personalities, vested interests, colleges, BMA, groups fighting amongst each other to say, “This is what I said, and he was responsible and I wasn’t” – is hugely disappointing. It is a hugely disappointing concept to think that, at this historic time, with this huge opportunity of the review and what the GMC is presently doing, to imagine that very talented people are going to spend time, picking over the minutes of meetings that took place in the last millennium. I do not think that it is not an appropriate use of time.

The only possible stance for the Council to take is not to talk about medical control or GMC control. You are quite right: you had already flagged up that word as being one which is not part of our current thinking. We are talking about partnerships with the public. And who more appropriate to have a partnership with than the individual who has been most associated with the introduction of clinical governance to the NHS?

To talk about that as pragmatism rather than principle is an utterly ridiculous and false antithesis. It is the only way that we can go, to talk to the NHS about how to continue this partnership. I think that what we are doing is quite right, therefore. To look back in anger is not the way that we should be going.

MRS GILLIAM CAMM: I support where we are in the review and the idea of a seminar. I think that the questions are quite right. I was not here when all these other things were going on, and I personally have absolutely no appetite whatsoever to trawl over all this stuff. We need to be clear about whose interests are being served by doing so, and I cannot see a scenario where the public’s interests would be served by doing it.

These are complicated issues. It is important that we have frank debates and then we understand what collective responsibility means – which is something that I thought we had established.

DR PETER TERRY: Like Gillian, I was not here during the conspiracy times, and I am quite glad that I was not.

MR STEPHEN BREARLEY: Nor was I!

DR PETER TERRY: I certainly do not recognise that kind of ethos at the moment. It would be wrong to describe this debate as a repeat of the debate we had at our seminar in December, but there certainly are a good number of similarities, and I suppose that we can continue to repeat the debate for as long as we like – but it will get rather tedious and will not be terribly productive.

As you know, I have some concerns over aspects of revalidation and our documentation: not so much in terms of the vast majority of the work with the NHS but very much in terms of the wholly independent sector and those doctors who may request revalidation from being overseas. I think that there are some genuine practical difficulties there.

A combination of what we decide or what will come out of the review, and what is decided for us or influences us in our consultations, will result in some kind of document and process that will have to be taken forward, to try and provide the patients and public with the reassurance that they deserve. I think that we are all signed up to that.
Whatever that is, whatever emerges from the process that will take place over the next few months, I doubt very much that it will be perfect. It will be as good as we can get at that particular stage. In December, I thought that we had decided at that stage to go forward on our own, with a process which we acknowledged would evolve over many years. Anybody who thinks that whatever process we come up with will sit there and be unchanged for 50 years is not living in the real world. So long as we are prepared to be flexible and responsive, and change whatever process is decided, by us or others, then I think that we can move forward in a constructive way which will benefit the environment for patients and the public.

I do not think that to go back to the idea that there was a model that, God knows how many years ago, was decided by whoever to be perfect and that we must stick to that, is living in the real world or is politically realistic.

**MS RUTH EVANS:** I was not there for the conspiracy either, but I was there for a lot of very impassioned debate amongst a lot of us who were extremely concerned about how the proposals would pan out. I think that there was an enormous amount of work done on revalidation, led by Stephen and the team, to try to get it right and to take into account the wide variety of views that there were, including the lay interest. I think that we did not get to a final solution, and that we all acknowledge in our calmer moments that, as Peter has said, this is not the end of the road.

There were gaps, there are gaps, and we ought to be quite frank about that – as some of us are at times. Stephen has said this on a number of occasions. We have not finalised the methodology at local level: how it will actually work. Dame Janet said the same last night and that there were – she may have used the word “holes” or that sort of expression. Yes, there are. It is not a perfect model. It would be very odd if it were, as it is the greatest reform to have taken place over the 100-and-whatever-it-is-year history of the Council.

I think that we have to be quite clear that we welcome the review, because we need help in making sure that it works well locally; and, from my perspective, and no doubt that of other lay members, that it has the involvement locally of patients and their carers in a way that we have not been able to demonstrate, because we have not put it into practice – something that I have talked to Amanda about in the past.

So let us not pretend that it is all done and dusted. There are holes; there are question marks; and Dame Janet has done an invaluable job in asking questions that we have to look at again.

Though people do not seem at all to take on Mike’s perspective of the history, and it certainly does not accord with mine, I think that it is useful for Mike to point out that, at the last Council meeting when we discussed Shipman, none of us were aware that, two days later, the Department would be undertaking this initiative – which did, frankly, pull the rug from under our feet. We can indulge in post facto rationalisations now, as some of us are doing, and say that we knew there would be and that the Department would have to do this. We did not know that. We had agreed as a Council that a letter would go out to doctors on revalidation two days later, and we had quite a debate about this.

So let us forget the rationalisations: we had not anticipated the Department would do this, nor did the Shipman Steering Group the day before. I think that what the Council leadership has done has been, very sensibly, to look at it and to welcome the way in which the Department has acted – perhaps not terribly helpfully in giving us the information at the right time. We did not know about it. I can quite understand why Mike is saying this. At our last meeting, when we were all together, we gave our blessing to the letter going out.

I think that what we have done has been absolutely appropriate and it has been properly led and managed; but let us not indulge in these post facto rationalisations, which say “We knew the Department was going to do it”. We did not, but we think that it is a sensible move.
THE PRESIDENT: I think that is largely correct. At the last meeting, at the internal conference on 15 December, I did indicate that there was likely to be a review. I did not know that it was coming two days later, and I did not know that it would pull the plug on the letter. To that extent, therefore, that is absolutely right.

DR SATI ARIYANAYAGAM: I too was not a member of the Council at the said time, but I do concur with the thoughts of Stephen and Jim on this issue.

The emergency of the conspiracy theory is highly regrettable. In my view, the issue around revalidation as a process to eliminate problems, and the current feeling about that, is about its adequacy, not about its efficacy. Nor is it a question of conspiracy. I do not think the report suggests in any way that there was a likelihood of some conspiracy having taken place.

In that regard, whether or not a conspiracy took place is – to me, as a current member – irrelevant. I go back to what has already been alluded to in terms of the public interest. To exhume bodies further at this stage will not serve the interests of the public. I think that we must go forward.

THE PRESIDENT: Thank you very much. I am not sure about the appropriateness of the analogy!

DR KRISHNA KORLIPARA: As a member who has been around for a very long time, I was present during the time when alleged conspiracies were supposed to have taken place, but I am not aware of it.

I regret hearing an eminent colleague such as Mike Pringle saying that we have lost control of revalidation. I can remember February 1998, when Donald Irvine introduced the concept of revalidation. Much has happened since, of course. Even if Mike were right, that we have lost control of revalidation — of which I am not by any means convinced — I do not think that should be the reason for our being coerced into doing something which we believe is not fit or fair for the purpose for which it is being developed.

As you may know, I was chairman of the GP consultative group on revalidation and I worked with Mike when he was the chairman of the RCGP. I cannot recognise that there has been any tectonic shift in the way we have developed revalidation as a demonstration of one’s fitness to practise. Yes, I concede that we have lost momentum for a little while, but we have not lost direction. Whoever takes over this function, I suggest, will not find that there are any easy alternatives. Neither did we say that we knew it all. That is why we have taken the time we have: because we are willing to learn and willing constantly to improve.

In my view, Dame Janet was appointed to look at the Shipman deaths and what lessons can be learned. In that context, I regret that she has exceeded her remit. In my view, she has seemingly been influenced by the evidence presented by the former president who quit the Council in difficult circumstances. I have to say — and it is in accordance with my conscience — that I hope Mike Pringle, in his views, is not speaking for the Royal College of General Practitioners. If that were the case, I think we would have a great deal to worry about. You know where I stand. I entirely dissociate myself from what Mike has said.

THE PRESIDENT: I do think that we need, to the extent that we possibly can, to look forward and not back.
THE VERY REVD GRAHAM FORBES: I will not look back to those halcyon days of, “I too was there, not taking part in any conspiracy”. I was probably sleeping at the time!

I think we are running the risk of, “If you don’t like the message, shoot the messenger”. We did not shoot the messenger last night; we actually fed her and listened to her. My view is that that is good.

The goalposts have moved. We might not like the movement, but it seems to me that, as a Council, we should unashamedly welcome that and, creatively and constructively – and not at all defensively – do what we can to use our new strapline: regulate doctors and ensure good medical practice. We must not go into defensive mode.

I actually feel quite proud of this organisation. When I saw you on “Newsnight”, I was jolly glad it was you rather than me! We had a hellish brief, and we were honest. Honesty and integrity will mark what we do. So let us not shoot the messenger – feed her, listen to her, take on board the menu or diet she has set and, for heaven’s sake, let us not be defensive.

RT HON KEVIN BARRON: I agree entirely with Stephen in his analysis that this review is not just about revalidation; it is about many other things. It would be surprising if it was not, in view of the fact that it is the fifth report on an incident in the UK’s medical history that is horrific from anybody’s perspective – and certainly from a politician’s perspective.

I think that we have nothing to fear. Given the work we have done with different partners in relation to revalidation, our voice will be heard in that review – not only by ourselves but also by other organisations who, through consultation processes, have endorsed what we have been involved in. I am not worried about that situation whatsoever.

I have to say that I agree with Jim Drife in relation to the issue of whether we should consider an inquiry into what happened. For that to happen, I have to say that it would look as if we were imploding on ourselves – and, in my view, completely overreacting to the Government’s decision to have this review at this stage. I do remember the time when people spoke in this Council and looked over their shoulder before they said anything. Quite frankly, I do not want to sit on a Council that does it again. It has taken many years for that to change, and I would not want to sit on a Council which reverted to that mode.

Jim is absolutely right: it is not an appropriate use of time or money to have any kind of inquest into why we are here. We know what is in front of us. We should just get on with doing it, on behalf of the General Medical Council and on behalf of the public as well.

THE PRESIDENT: That is enormously helpful because, as you know, the staff in this organisation is pretty hard-pressed. Looking forward is bad enough; looking back probably does not help a great deal.

DR ALEX FREEMAN: I am another person who welcomes this review, partly because when I first read the recommendations in the report I was struck by a great sense of irritation – particularly when some of the recommendations talked about a General Medical Council which I did not recognise. Having been on this Council since 1999, I feel that the Council we have today is very different from the previous Council. I feel that we are working together; that everybody has their opinion and expresses it; and that we work by consensus, in terms of what we are actually here for. It is very unhelpful for recommendations to talk about medical
versus lay membership. We are all here as members to do a job – and that is the job we need to do.

A huge amount had been done on revalidation and, whatever my personal view on whether it is a good or a bad thing, I did feel that we were getting there. There were still some unanswered questions. Over the years, an enormous amount of effort has been put into developing a system that is as good as it can be at ensuring that doctors are up to date and fit to practise, while at the same time ensuring that it is practical enough, such that doctors will do it without it placing an unreasonable burden on them and detracting from the care of patients – which, after all, is what we are here for.

It would be useful for people who have not been involved all along to appreciate how we have got to where we are, but reopening some of the past debates is singularly unhelpful. We need to look forward now from where we are. Some of the recommendations are coming up with old chestnuts which we have discussed before. In fact, the only unanimous vote on Council that I can remember from 1999 was in relation to the standard of proof in fitness to practise, where we all agreed to keep the criminal standard of proof. It was not surprising to me to see that debate being reopened, because I feel that there are outside influences which would prefer that we perhaps did not use it.

However, I do welcome the review. I hope that there will be good input into it. I am also happy that someone will go through the report and detect the inaccuracies in the conclusions where they do not seem to be upheld by the evidence. Certainly that was one of the things that irritated me when I read the conclusions. I read the evidence put forward by the GMC. I have not read it again recently, because I read it at the time. That was probably the source of my irritation – knowing that things had been said and conclusions drawn which were patently not supported by the evidence. So let us move forward.

PROFESSOR CHRIS BULSTRODE: I must have been labouring under an illusion. I had thought that appraisal and revalidation were being set up to identify poorly performing doctors. It is now clear that is not to be. I do not think that it ever could have been, but it is obviously not to be. It is to be a reaffirmation of positive practice. So be it.

I am also very happy to be working in partnership, but I think that we should be very careful about not letting that obscure that we can work in partnership but we have a responsibility which we have to fulfil. It is no good passing that responsibility on to someone else, in the name of partnership.

My understanding is that responsibility is to promise to the public that we will ensure that doctors are safe to practise. Can I therefore urge us to get on with the job of putting in place, whether in partnership or whatever, the tools we need to assure the public that doctors are safe to practise? If Dame Janet has her way, I and several others of us will not be on this Council much longer, and I would like to see some progress before I go!

THE PRESIDENT: Tempting as that scenario is, there are a variety of different ways in which you can do that, not least through the educational side and so on.

Making sure that doctors are up to date and fit to practise is not dependent entirely on catching the miscreants. I am not suggesting that is not an important aspect, and I think that it is something we have to come back to deal with when we have the seminar. However, there are a variety of safety issues here that need to be put in place, one component of which is fitness to practise. The whole ethos, the whole way in which the profession works, is clearly dependent upon patient safety.

I was listening to a talk by a man from MI5 or MI6 – and Kevin will know far more about this than I do. The Government’s approach to security is not just dependent upon catching people
who may or may not be potential criminals: it is putting in place a whole system where that becomes increasingly difficult or unlikely to happen. I do not want you to correct me if I am wrong, Kevin. This is my belief and I am going to hold with it, regardless of evidence – and I have precedent for doing it!

**DR JOAN TROWELL:** Revalidation is not our sole mechanism for dealing with issues of fitness to practise. As you have said, President, it would be very foolish for anybody who has concerns about a doctor to wait five years to report them. We need to flag up and remind people that there are other mechanisms in place.

However, in thinking about that – and obviously I am familiar with that work in my role as chairman of the Fitness to Practise Committee – I would remind Council that, more than a year ago, we looked very hard at the way in which our fitness to practise processes fitted in with clinical governance and with the local procedures. In taking forward our policy on early disclosure, we work with local trusts and the local clinical governance mechanisms. These links which we have taken forward are actually another way of working in with the appraisal process.

I would remind you also that appraisal was not in place when revalidation was first floated as a way forward for this Council. Therefore, in looking to take advantage of local procedures that have been put in place since, we are in fact doing exactly the same as we have already implemented in our fitness to practise procedures, in establishing early dialogue with employers and with the local clinical governance processes.

To take forward any of our work, whether it is fitness to practise or revalidation, we cannot work in isolation as a Council. We have to work with the rest of society, with the views of the public, the profession, the Government and of those responsible for running the health service, which employs the vast majority of doctors in this country.

In taking forward these views, we must work to a solution that has the trust of everybody. There is no point in our holding a register, the integrity of which is questioned. I would therefore welcome this review from the Chief Medical Officer. I welcome your view that we should work with it and work forward, to hold a register that has the trust of all parties concerned.

**THE PRESIDENT:** By working in partnership, we do not work in isolation. We do have absolute responsibility for the register.

**PROFESSOR WENDY SAVAGE:** I have been on this Council for a long time, since 1989. Whilst I never felt frightened or was looking over my shoulder, as Kevin has described, I think that the way revalidation developed is misunderstood by the summary that Dame Janet gave and which Mike has reiterated this morning, namely that there was a change of philosophy in 2001.

I did not make revalidation my major interest because, as someone about to retire then, I thought that it was not really up to me: it was up to younger doctors. However, I recollect that, after the first Council seminar when revalidation was sprung upon us by Sir Donald, we then had another seminar which was in Hallam Street. I was in Stephen Brearley’s group, and I remember distinctly the discussion we had – that the whole point of revalidation was not to detect bad doctors, but it was to confirm that the majority of the profession were fit to practise. There were other mechanisms, as Joan has said, for picking up the bad doctors.

I therefore do not understand why Dame Janet got this date as 2001 in her mind as when we had a change of philosophy. I do not think that we have ever had a change of philosophy. As
everyone who has spoken and who has been through the process has said, we started with an idea; we worked on it and we consulted. We came out with a proposal, having worked well with government, which we hoped would make sure that revalidation – a word I hate! – worked, and would not waste enormous amounts of doctors’ time, which would be better spent looking after patients.

There was one thing which I had always thought might be useful to have in the revalidation folder and which Dame Janet talked about, namely a knowledge test. Looking at the doctors who have come to the performance procedures, so often it is the basic knowledge that seems to have led them into the situation they find themselves in. As we take this forward, I hope that we will perhaps give a little thought to whether, for those doctors who have been overseas or for those working in the private sector, which would be a useful thing to do.

I am sorry to disagree with Mike, but I really do not think that this Council went through a change, a u-turn, or whatever, in 2001. I think that we are going in the right way, and I hope that we will get it right in this review process.

MR FINLAY SCOTT: I too think that it is right to welcome the review, and I think that it is important that it is a review and not an inquiry. There is a fundamental difference. I am reminded of Churchill’s words: “It is better to have jaw-jaw than war-war”. The review provides an opportunity for that.

I think that I too am entitled to reminisce today, because I have a unique claim, which I am happy now to stake out for you. It is that I am the only person in the universe who can say that they were with Sir Donald when he signed the “Dear Roddy” letter in June 1998. Indeed, Sir Donald generously acknowledged recently in a conversation that I drafted the “Dear Roddy” letter in June 1998, and therefore I can claim to have some understanding of what has happened between then and now.

I said to the Council in about 1999 – and it was recorded at the time – that, for the first time in our history since 1858, we would be dependent upon others for the discharge of a statutory function, because it would be impossible to implement any model of revalidation that did not build upon local systems, and specifically systems within the NHS: a point that was fully acknowledged by the Council at the time. That is the basis on which we have been working with the Government since 1998. If anyone believes that the Government has been busying itself with other things while we have unilaterally been developing revalidation, then I think they misunderstand the nature of the real world. That, of course, is reflected in the legislation that was put in place in 2002.

As it happens, I think it is very important that we look forward, but I am bound to say that one cannot both look forward and look back. If I may say so, Mike may be doing us a favour by encouraging us to ensure that the journey on which we embarked in June 1998 is properly laid out. I do not think that should be the first call on the time of your hard-pressed staff, but I think that it would be useful to document how we travelled the road from June 1998, if only to enable us to make clear that we have nothing to hide; there have been no conspiracies; the issues have been fully discussed; and that when there have been shifts, as indeed there have been, they have been thought through and presented openly.

I have a private confession to make. I am truly sorry that I cannot call myself “Dr Scott”, and it is clearly too late for me to go to medical school. So I was proposing to use the development of revalidation as the basis for my PhD in my retirement. If you would allow me to begin to embark on that task, I would be very happy to write up an account of the almost seven years since June 1998. I think that what it will show is that we have known what we were doing. I really cannot improve on the description of revalidation given by Sir Donald as recently as 2003, when he said, “Revalidation is about the positive affirmation of good practice. It is not about the negative identification of bad apples”. That has always been the case, and the account will show that.
In relation to what Sati has said, if I may say so, it would not be about exhuming dead bodies but about interring some calumnies that need to be laid to rest. If you give me a little time to do it, I would be happy to undertake the task.

Finally, as a matter of information, because of the delivery of the sixth report on Thursday, we think it is important that we get our comments on the fifth report to the inquiry. It will probably have to be tomorrow, so I am sorry that there will not be an opportunity to circulate them to you in advance of that – but of course we will let you have them as soon as they are submitted.

THE PRESIDENT: We have had a pretty helpful debate, I think – at least from my perspective. We are back to recommendation 2a. Are we content? [Agreed]

PROFESSOR WENDY SAVAGE: I have just noticed a “stakeholder” in paragraph 22(g). I wondered if we could just say “interested parties” or something like that.

[A short break]

THE PRESIDENT: We are still on paper 6a. We have only covered the first recommendation, and I want to move on to the rest of the paper.

I would just remind you that, in our response to the Government’s indication that there was to be a CMO’s review, we have said with regard to revalidation that we are very happy to take advice and, if there are ways in which our model can be improved, we are open to that. I took that to be the tenor of the debate we had before coffee. It is perfectly clear that we need to get that through to the CMO and to the Government as quickly as we possibly can.

You will be delighted to know that Paul Buckley will take us through the rest of paper 6a, recommendation 2b, starting at paragraph 23.

MR PAUL BUCKLEY: Paragraphs 23 and 24 of the paper record the inquiry’s conclusions in relation to the handling by the GMC of Shipman’s convictions in 1976. As paragraph 24 makes clear, Dame Janet concluded emphatically that, from the information available to the GMC in 1976, the GMC could not have suspected Shipman’s true nature as a serial murderer; and that, from then until his arrest in 1998, the GMC cannot be held responsible for the fact that Shipman remained free to practise.

That of course did not lead to any recommendation, because there was no need for it to do so. It was a finding that sometimes tended to be overlooked in some of the reporting of the inquiry. Nevertheless, it is extremely important, not least because the express remit for the inquiry was “by reference to the case of Harold Shipman to enquire into the performance of…” – the various statutory bodies, including the GMC, that were involved. One recalls this without any satisfaction, of course, but it is nevertheless important to note that.

Going on to the issues in the report that did lead to recommendations, you will have seen that annex A to the paper sets out the recommendations that relate directly to the role of the GMC, recording in the right-hand column some provisional conclusions which have emerged from discussion at the seminar which the Council had in December, but also from discussions at the Fitness to Practise and Registration Committees. Those are some provisional, emerging conclusions; but it is immediately apparent that, first, only about half the recommendations relate to the GMC and, second, of those, a considerable number already reflect current
practice or policy. There are some that need to be considered, either through the CMO’s review or by the relevant committee; nevertheless the picture clearly emerges of a report which is building upon and strengthening an existing direction of travel, rather than recommending wholesale changes to it.

That is the general picture. The rest of the paper goes into some of the detail, starting at paragraph 26 with issues relating to culture, constitution and governance. Once again, it was easy to overlook some of the important conclusions that Dame Janet reached on these matters. There was an expectation that she would recommend that professionally led regulation in partnership with the public should be replaced by a quite different model. She did not do that. In fact, she did the reverse: she made quite clear that the GMC should be dominated by medical members. She explicitly endorse the model of regulation that we advocated during the course of the inquiry, whereby there is professional ownership of standards, but alongside strong public involvement, accountability, and transparency. Again, I think that it is important to pause on that and, as it were, to take delivery of it, because it was a point that was either misreported or was not reported at all, following the publication of the report.

Nevertheless, Dame Janet concluded that, while there had been significant cultural change within the GMC, particularly over the last five years or so, she believes that further change is required; but it would depend on altering the constitution of the GMC so as to remove the elected medical majority that we currently have.

The hearings into the GMC, during which the President, Finlay and others gave evidence, took place in November and December 2003, which was only about four months after the reconstitution of the Council in July 2003. The issue of the elected medical majority was not explored with witnesses, certainly in any depth. It is a conclusion that Dame Janet has reached on the basis of inferences that she has drawn elsewhere, rather than on direct evidence that was actively explored and enquired into. Some of those inferences, as the paper records, are based on misunderstandings. Nevertheless, Dame Janet’s point of view clearly deserves very serious consideration and debate, and it will be among the issues to be looked at as part of the CMO’s review.

Quite separately, the business plan which Council adopted in November 2004, before the report was published, included a commitment to undertake by October 2005 a post-implementation review and evaluation – which we call PIRE for short – of the governance changes introduced in 2003. A PIRE is an internal control mechanism used to evaluate how well major policy initiatives were implemented. Typically it will consider, first, whether the changes that were planned are actually now in place and, second, are they delivering what was intended?

It would clearly make sense, as the paper argues, to bring the PIRE forward, in order that it may contribute to the CMO’s review. We may also need to consider whether the PIRE should go beyond merely looking inwards at the GMC and consider, for example, what the current state of play on best practice on governance is in the public sector. Only a couple of weeks ago, the Office for Public Management issued a report from a group chaired by Sir Alan Langlands, called The Good Governance Standard for Public Services. That set out principles for good practice in public sector governance. It would be a pity if, in undertaking the PIRE, we were not able to benefit from an external dimension of that kind.

For the moment, however, the recommendation in 2b is simply to agree to bring forward the PIRE. If that is agreed, then we propose to circulate some draft terms of reference for you to see.

THE PRESIDENT: So it is discussion on the paragraphs leading up to paragraph 36 and the recommendation there.
DR BRIAN KEIGHLEY: As Paul was speaking, Bob Nicholls and I looked at one another, remembering the very hot summer during which we laboured in order to get to where we did in terms of the recommendations for this new Council’s constitution.

I would support the recommendation that this should be brought forward, but I think it is important that, when the CMO is looking at this, we resuscitate the consultation papers that we produced. There was an interim report and a final report. There are some ideas within the interim report whose time may have come. I think specifically about the penny-farthing model. However, we have to remember that Sir Liam was actually part of that process. He was sitting in the chamber when we went through those long debates as to how we should reconstitute ourselves.

I think that those papers, the discussions, the consultations that we went through, and the principles we followed would benefit from seeing the light of day again.

THE PRESIDENT: I agree with that, Brian.

MR BOB NICHOLLS: I have been slightly taken away from my opening remark in the pre-coffee debate, but I think that the balance of both the writing and how Paul has introduced this is extremely important.

There are some major things here: that this Council is not responsible for missing Shipman; Dame Janet has not recommended the removal of the professionally led, publicly accountable aspect; that the medical majority should continue. They are all points that some of the older lay members, and those working on governance, as I have been reminded by Brian, thought were very important principles – and these have been endorsed.

I absolutely agree with the recommendation. We need to advance the review of the governance. I just make the point that I made before: that it does need to be in the wider context. As a small example, taking one of the later papers, if there are no Council members to be involved in any casework – not something I will necessarily support – if that were the conclusion, then all we would be left with is trusteeship and governance. I would suspect that the paper to which you refer, and other private and public sector recommendations about governance, would have said this was far too big a Council for that; yet it is clearly too small a Council in terms of representation.

It is important therefore not to signal that there is a lack of evidence with that part of her report – and she made the point again very strongly last night – that democratic representation is the weakness. I think that there are all sorts of other interesting things, on which there may be more evidence and a debate to be had. The important thing would be that we have reached no conclusion about that interesting proposal, but that we do need to review governance in the light of things that have moved on externally and internally.

SIR MICHAEL BUCKLEY: I would first like to say what a good set of papers I thought these were. I think that the secretariat have done an excellent job.

We shall be talking later about adjudication, but there is an important link between that and the makeup of the Council. If, for example, we were to lose adjudication, then it would essentially be maintaining the register, education, and standards. The arguments against having a sizable number of elected medical members become far weaker. Much of Dame Janet’s argumentation is based on the proposition that elected medical members, so to speak, cannot judge their peers because they have an interest to defend. That argument falls if we lose adjudication.
It is therefore important that – building on Bob Nicholls’s point – before one reaches a view about the composition of the Council, one needs to be clear what the Council is going to do. That said, I entirely agree with the recommendation. It is obviously sensible to bring the review forward. However, we need to bear in mind the cross-links with some of the other issues that we shall be discussing.

**THE PRESIDENT:** I suppose the argument might be put forward that the argument has already fallen, because nobody sitting on the Council now sits on any of the adjudication panels. The initial impetus for the recommendation may well have gone, therefore. Nevertheless, I think that there is still an argument there that we should grapple with, and see whether or not there are advantages to changing the composition of Council.

**SIR MICHAEL BUCKLEY:** I am not saying I agreed with the argument in the first place. What I am saying is that it could become significantly weaker. To come back to the central point, before you decide on the composition of a body to do something you need to know what it is that they are going to do.

**DR PETER TERRY:** I was not clear from the recommendation – and this relates to the number of the elected medical members – whether or not it is the majority that she objects to, or indeed whether we should have any at all.

My reading of the report is that it is an elected medical majority to which she objects. When she was speaking last night – and having discussed this with others – it appears that it is this whole principle of representation, or a representative element on Council, to which she objects. I would like some clarity in relation to that recommendation.

I will not say whether I agree or disagree with it, but she has emphasised the representative nature of the election. What she has not emphasised is, as it were, the medical buy-in to the whole process, as part of professionally led regulation. It was much the same with medical management when the vast majority of doctors were taken out of management. Their view was then, “We’ll just let the medical managers get on with the management and we won’t participate in it.” There certainly has been that kind of tendency and philosophy evolving over the last ten to 15 years. I do not think that would necessarily be appropriate in regard to the profession’s view of how we are regulated.

**THE PRESIDENT:** When you say clarity in relation to the recommendation, you mean clarity in Dame Janet’s recommendation as opposed to this recommendation.

**DR PETER TERRY:** Yes.

**THE PRESIDENT:** Some things I can attempt to do and some things are beyond even my powers. However, she does come at it from a particular direction, which was fitness to practise; she does not come at it from an overarching view. Whereas I think, when we consider this in greater detail, it is that overarching view we would need to have. My own reading is that it was not that she did not think that there was a place for elected members: she just did not think that there should be an elected majority. But I am happy to be corrected on that.
PROFESSOR WENDY SAVAGE: I have not finished reading all these recommendations, but I think she did recommend that, instead of having elected members, all the medical members should be appointed by the Privy Council. Is that not so?

THE PRESIDENT: I do not want to have a debate here, because we do not have the facts in front of us; but that is not my feeling. It is that she thought the overall elected majority should go, and there ought to be appointed members – but that was not necessarily the only route by which you could get on to the Council.

MS RUTH EVANS: For the record, I too, like most of us, thought that this was an excellent report – so well done, Paul. It is really good stuff.

On recommendation 2b, many of the ideas contained in Dame Janet’s report on governance is common currency amongst those who are involved with regulatory reform elsewhere. The ideas are well known, the arguments well rehearsed, and there are practical solutions at hand – certainly in the other regulatory bodies with which I am involved. There is a new, modern way of looking at regulatory frameworks. For example, whether you have elected doctors on this Council and whether separation of fitness to practise will count, frankly, is neither here nor there. It is setting standards that is important. It is the whole lot. Taking away adjudication would not affect her arguments.

The reason I say all this is because I very much hope – and I think that I heard someone from the GMC staff side mention it last night – we would be getting in some external support to take us through the review process. I know that we did not do it for Brian’s group and, at that point, I think that we needed to establish the way forward ourselves. But it would be enormously useful if, at low cost and not terribly involved, we could get in an external body to help guide us. The literature is there; the models are there; the Better Regulation Task Force, apart from anyone else, has this sort of thing up-front. There are a lot of very sensible arguments that we do not want to have to rehearse inwardly. That would not do us much good. We need to go forward.

I think that an external, objective hand in helping us analyse what is contemporary practice, what works, what does not work, why Dame Janet said what she has said, would be a very helpful move for those of us who are less involved in governance.

THE PRESIDENT: Perhaps Finlay could pick up that specific point now.

MR FINLAY SCOTT: I am grateful to Ruth for that. Paul, and indeed Andrew, have been giving some thought to this, because there is now a good deal of literature available. What we had in mind was that we might not necessarily get an organisation as such, but that there may be particular individuals who have contributed. For example, Dame Rennie Fritchie contributed to the Law Society.

Another potentially significant thing is that Alan Langlands has just chaired a group which has produced a very good report on governance in public bodies. So I am grateful to Ruth for that affirmation of the value of trying to get an external perspective.
DR KRISHNA KORLIPARA: Dame Janet has come up with a number of conclusions, many of which are not supported by evidence. I entirely support recommendation 2b, that the planned post-implementation review should be brought forward. However, in conducting that review we should take into account some of the comments made here.

The observation she has made defies logic. That is, that it will not be possible “so long as the majority of the members of the Council are elected by members”. It is obvious, to say the least, that she does not believe in the democratic process.

If we go back to pre-1979, before the review which was undertaken by Merrison, we did not have a system of an elected majority. The reason why the Merrison review was needed was because it was lacking the profession’s support. It is stating the obvious that, for professionally led regulation to work, two components must be fulfilled: public trust as well as the profession’s support.

She has not produced one iota of evidence upon which she could justify that the elected majority are more representative than regulatory. As many here may know, I sat on the PCC for about 12 years. If anything, I found that it was often the elected members who were much harsher towards their colleagues than the lay members. The elected members are much harsher because they know of the disgrace and the bad name being brought about by the actions of a few.

Simply because Dame Janet says this, we should not view it as the Holy Grail.

THE PRESIDENT: We are in danger of indulging in the debate today. What we need to do is set the scene. It is only comparatively recently that we lost a large number of appointed members, albeit by a different route, and there may be advantages in looking at the balance. I suggest that we are not looking at a pendulum swing that completely removes elected members.

DR KRISHNA KORLIPARA: I am happy with that, President. I just wanted to point out that we should not go the other way, simply because someone as eminent as Dame Janet has said something.

THE PRESIDENT: I think that is right.

PROFESSOR JAMES DRIFE: It seems quite a short cycle for the wheel to come full circle, but it used to be that the GMC was set up entirely with members appointed by medical bodies. The introduction of democracy was seen to be a needed reform. A lot of us did feel a slight unease that there were very few appointed members at the last reshuffle, and maybe a rebalancing might not be a bad thing.

The value of the link, as Krishna says, between the GMC and the profession is dangerous territory to tamper with. We cannot just go round with a big stick; we do need to have the hearts and minds of doctors, as well as punitive action.

MR FINLAY SCOTT: I apologise for making a second contribution on this point, but I wanted to see whether it is right to distinguish two things – although they are both very important.

The original concept of the PIRE was – and this draws very much on what Ruth was saying about the need to get an external contribution and a sight on this – given what led to the reconstruction of the Council, has it been implemented and does it work? Should we be
making changes? For example, how can we strengthen the governance function – whatever its composition – of the Council? I think that is a valid continuing requirement and, essentially, the paper says we should bring that forward.

In a sense, what we have is a second and, strictly, a separate issue which is around the composition, i.e. how people get on to it. Dame Janet has advanced a line of argument which, it is clear, a number of members – not only elected medical members – have not so far found persuasive. This really picks up Brian’s point. When we take forward the work that I hope you will now to authorise, we should address both sides of that. Even if the composition of the Council and how members got to the Council did not change, it is worth reflecting on the past 18 months, soon to be two years, on what lessons might be learned.

That is the force of what I want to say. I think that when we take this forward, although these two elements are complementary, how we address them may be different. The first will be about drawing upon good practice, as Ruth has indicated. The second may, at the end of the day, boil down to judgments and the judgment on how best to strike that balance between the independence of the Council, its statutory purpose, but also the undeniable need – which Bob has frequently taken us back to – to continue to command the confidence of the profession.

**MS RUTH EVANS:** I totally agree with what Finlay says. I think that there is a misunderstanding – although I have not read this bit of the Shipman Report – about appointed members, which perhaps Council ought to be aware of.

It is not the old-style appointed members. I hope that people understand that. It is appointed on a system of openness, transparency and merit, through open advertisement and recruitment. So it is a completely different system, which people may or may not agree with. We are not coming full circle; we are going to a new regulatory model. My understanding is that medical members would be appointed on the same basis as lay members. Whether or not you agree with it is another matter, but I think that there is some misunderstanding. It is not going back to the old way.

**THE PRESIDENT:** I understand that. However, it would allow some medical members to express particular interests – someone who has an educational bent, or who is interested in standards and ethics, or whatever – and to put that forward as one of the reasons why they might come on.

**MS RUTH EVANS:** Yes, it is just that they will not be appointed through medical royal colleges in the same way.

**THE PRESIDENT:** Are we content with recommendation 2b? **[Agreed]**

**MR PAUL BUCKLEY:** Paragraphs 38 and 39 deal with another governance issue raised by Dame Janet. In recommendation 50 she says, “There must be complete separation of the GMC’s casework and governance functions at the investigation stage of the new fitness to practise procedures”, and that this must be reflected in the rules.

It has already been the case for some time that there is no involvement of Council members in fitness to practise casework on the adjudication side. The role is one of governance. She has recommended that this should also apply and be made explicit with reference to the
investigation stage, albeit that it is our current operating practice. The recommendation at 2c invites Council to make explicit what is currently implicit.

THE PRESIDENT: Given that this is what we effectively do at the present time, are people generally content?

MR STEPHEN BREARLEY: I did express some doubts about this recommendation, President, to you and to Finlay by email. We had a very useful seminar yesterday. One of the things we recognised was that some of the determinations we were looking at were surprisingly short and failed to give reasons for their conclusions – a criticism which I feel might also be applied to these two paragraphs.

Paragraph 39 starts, "Dame Janet's point is well made…", but it is not made here. Without going back to the original documents and looking them up, I am not quite sure what her point is.

The second thing is that the report points out that, "although the operational intention is that Council members should not sit on panels…". My memory may let me down, but the last time I remember this being discussed I am sure that Joan Trowell said that all members of Council would be welcome to take part in the work of the Investigation Committee if they wished to do so – subject, no doubt, to some assessment and training. So I am not clear that it was the operational intention of the Council, although it may have been the operational intention of some people within or working for the Council.

My position today is not that we should formally reject the recommendation, but that we should defer it. This is a complex issue and there are arguments on both sides. I certainly feel that my understanding of both fitness to practise and registration issues is enhanced by the fact that I have been practically involved in doing casework over the course of years as a Council member. I have some concerns about how knowledgeably and wisely one can govern a process of which one has no first-hand experience.

Another issue here is that Council is being asked to endorse a principle which affects not only fitness to practise but also registration, yet in fact the next recommendation is that we on the registration side should effectively be asked to decide whether we wish to go against a principle which this recommendation is asking the Council to endorse.

I am bound to say I think that would put us in difficulty. There is no urgency about taking this decision, and I would prefer this recommendation to be taken away and brought back to us with the benefit of a rather more fully argued paper, so that all members can think more fully through the issues than these two paragraphs perhaps encourage them to do.

DR PETER TERRY: I agree that the recommendation should be considered more fully, but perhaps come at it from a different point of view. I have always been very keen on the separation of governance from those who are governed, simply because it is difficult to govern yourself objectively. However, I think that is too simplistic an argument for us to debate at the moment and we do need more information.

My real point for asking to speak is a related one, about which I did ask for some information at the JCC but have yet to get. This is related to the idea that comes through the report: that a lot of the things we have in our guidance should be written down in the rules.

As I understand it, we were encouraged by the Department of Health to write guidance because it is then very much easier to change things, and that we should keep the rules to a minimum – and indeed we have done that. As you know, I asked Sir Liam what the
Department of Health now thinks. I am sure that you do not have a reply, but I just wanted to raise it as a generic issue that comes through the report. Are we to reverse what we seem to have been doing, namely to write things in guidance rather than rules, or are we going back to rules?

**THE PRESIDENT:** The discussions I had with Sir Liam indicated that we should not be seeking to change that which is established practice, until such time as there is a decision that we should do that. I am sure that is right. To maintain the status quo until somebody decides to change it must be a reasonable principle from which to start.

While this recommendation from Dame Janet may be endorsed, I do not think we work towards that objective yet. In other words, I think that we should stick with the guidance, allowing change as we think fit rather than becoming dreadfully immersed in rules that require somebody else to change – with all the problems that creates, not just for the legal services within the Department of Health but much more broadly than that.

Coming back to the specific issue here on the fitness to practise, at the present time my understanding is that nobody in the Council does actually sit on any of the fitness to practise casework committees. Joan, do you want to speak to that?

**DR JOAN TROWELL:** I would like to speak in support of this recommendation because it encapsulates the reality of what is happening. I have been quoted by Stephen, and I do not have the transcript of what I said on the last occasion. My memory is that the point I made is that our current legislation allows members of Council to sit on the Investigation Committee; but on that occasion I was speaking to Council to ask you to endorse the facility to recruit some of our fitness to practise panellists also to be trained in this procedure. If that is not what I said, I will subsequently apologise. That is my memory of what I was debating.

On that occasion, Council endorsed the principle that we could recruit and train fitness to practise panellists in the Investigation Committee and, on that occasion, we asked those members of Council who wished also to be trained to identify themselves. It is fine to have a principle that Council members should be involved; none of us can put a gun to the head of another Council member and say, “You will do this work”. That is the reality of where we are.

The principle involved is one to which Peter has alluded. I believe very strongly that our role as Council members is to take forward our governance role. The Fitness to Practise Committee will, I am sure, sympathise with the sentiment that in the last 12 months we have been fully occupied with this role. I am very grateful to the members of that committee for working extremely hard on developing our policy, and for Council members’ support to the legislative changes that were being introduced and backing the staff who were working through the implementation and the guidance that has had to go into the new reformed procedures.

I hope that your experience yesterday afternoon gave you some insight into the audit work that we have also set up. That is time-consuming for Council members and I believe that, if we are to do that audit work, it would be invidious – and it has been said to me in so many words – for some Council members to be auditing other Council members. Whether or not that is a reasonable thing to do, I do not know; but I think that it is a role we have to take forward. It has been extremely helpful in pointing out areas for further policy development, and further training for the people doing the work. As somebody who has applied audit in other parts of my life, it is a privilege to be able to bring it to the Council and to set it up here.

There was another learning objective to yesterday afternoon’s work. Like any good teacher, I told the class of only three of my learning objectives, having been taught that you should only have three and, if you had others, you should not tell the class what they were. I did not tell you, but some of you twigged. You were bright enough to come up to me afterwards and say,
“Of course, what it has taught me is a great deal about how we can learn about fitness to practise work, without actually sitting on the panel”. It is another way in which people can become involved in understanding the subtleties of this work without actually doing it, and gaining the experience they need in order to take this forward.

From that point of view, therefore, this recommendation identifies where the Council is at the moment. It sits quite comfortably with some of the other policy work we would like to take forward in relation to the fifth report, and I would put it to Council that, while you may feel it is appropriate to defer, there is also a great deal to be gained by agreeing this principle – at least in the fitness to practise directorate – that that is where we are and where we move forward from.

THE PRESIDENT: I am slightly reluctant to pursue this in any great detail. We have just a couple of paragraphs and we have to make a decision on the basis of not very much information in front of us. We can do that if there is a need to do it, of course, but I wonder if that could be incorporated back into the post-implementation review that we have already agreed to set up – to give us a chance to look at it more objectively, so that we can see what the pros and cons of this are.

I am happy to keep on with the debate, but there is no particular reason for forcing it today – if we want to take a little while to reflect.

DR JOAN TROWELL: While I do not wish to force anybody to make decisions that they do not feel sufficiently informed or ready to make, and I accept your suggestion of the post-implementation review, I think that it would be helpful, in planning the work of the Fitness to Practise Committee, to have at least some steer that the Council is behind the line of governance work that we are trying to take forward.

THE PRESIDENT: I am sure that is the case. The fact that nobody sits on these case committees at the present time is a fair indication of the importance that they attach to them. It is somewhat different to making a decision today.

DR KRISHNA KORLIPARA: I am very glad we are not making the decision today. I am entirely with Stephen on this issue. We have, quite rightly, already debated the separation of investigative and adjudicative functions, in the hope that, by erecting a Chinese wall, we will retain ownership of one and lose the other. It would now seem that we are going to lose the ownership of both – the investigative as well as the adjudicative functions.

You are well aware, President, that I am in favour of completely hiving off the adjudicative function, which we stand to lose whatever decisions are made – especially if the decisions are not in accordance with public perception. I entirely agree with Stephen. Last time we were promised – because I was one of those who spoke to it – that Council members should be able to sit on the Investigation Committee and that we should be able to be actively involved. It would be a very sad day if we reneged on that.

I suggest that we should not take a view. We should simply come back to the Council when all the issues have been discussed, so that we can take a more reasoned approach. However, what I do advocate at this stage is that the Fitness to Practise Committee looks at the adjudicative function. That is the one which needs urgent review. That, more than anything else, could call into question the GMC’s ability to keep control – when in fact we have no control on the panellists. It does not matter how many controls or how many indicative sanctions we have: they will act in accordance with their subjective assessment. I
think that the time cannot come too soon for this Council to divest itself of all functions related to adjudication.

**THE PRESIDENT**: It will come in about ten minutes if we get ourselves organised, because it is on paper 6c.

**MS RUTH EVANS**: I was of the view that members ought to be involved in investigation. Over the weeks, I have changed my view. Whatever my views are is not terribly relevant, but I do think it important that we remind ourselves of what Dame Janet said last night about the expertise, skill and training required to undertake these functions properly. Investigation requires the same level of attention and training as adjudication.

I think that yesterday’s exercise was invaluable, but it showed me that, frankly, we may not have the necessary training even in audit. All of this has led me to look forward to 6d. More urgently, however, if we could perhaps find some wording which accommodates Stephen’s desire to look longer and harder, that is fair enough – but we do have to say it in a way which gets the message across that everything else is an endorsement. If we do not give out the message today that we understand there is a need for separation, I think that it will do us an enormous amount of harm.

**THE VERY REVD GRAHAM FORBES**: I would like to take 2c and 2d together. One of our besetting sins – or should it be virtues? – is about consistency. I think that we should have the same principle governing fitness to practise and registration. My personal view is that it must be separation.

Being a bit long in the tooth, I fought long and hard for the exact opposite. But it seems to me that what we have learned from Dame Janet, and the whole notion of a smaller Council, fit for purpose, et cetera, is that our governance function is key. In terms of the implications of working that out, I think that we are slightly further on vis-à-vis fitness to practise than we are vis-à-vis registration.

From my jaundiced perspective, we are unashamedly a governance-type body. That should be our principle. In terms of how we work that out, we might need to pause, to let registration – using my loaded language – “come up to speed”. Otherwise, we are just reinventing wheels and retreating to a former century, with dinosaurs and so on – “he says neutrally”!

**THE PRESIDENT**: What you are suggesting, I think, is that, while you yourself would favour a separation, you are not forcing the issue today.

**THE VERY REVD GRAHAM FORBES**: It is critical that in our key roles – registration, fitness to practise – the same underlying principles govern. For me, the governance one is key. Others will take a different view. In both of these key activities for us, the same principles should undergird all we do.

**THE PRESIDENT**: Inevitably, although these are matters that the committees themselves may wish to discuss, at the end of the day it is a matter for Council how these things are done. I think that it has to come back here, if we are not going to decide today.
MR BOB NICHOLLS: I associate myself with what Graham has said. Like Ruth, I have changed. When we were considering what were our core functions, registration, investigation and prosecution were deemed to be core functions. To my mind, that somewhat justified this over-large Council for governance purposes. However – and it is helpful to have the words on page 959 – it is exactly Peter Terry and Joan’s point. It is not human rights, which we have covered by separating adjudication: it is governance versus doing.

You combine the two and say, “As a matter of principle, we believe the separation is right. Would the two committees – fitness to practise and registration – look at how that should be enacted and report back?”, bearing in mind that in a previous item Council has agreed that we are going to look at governance. You need to say all that in the round because, in the end, if you do follow this principle, we will want a smaller Council.

THE PRESIDENT: Perhaps.

RT HON KEVIN BARRON: This is a decision we have to make. Like the last three speakers, I am quite happy that, if we do not want to do it this morning, we have the debate and take the decision. I think that we will have to come to the conclusion that investigation cannot stay with members of this Council.

I go back, like Bob and Brian, to the Governance Working Group which was set up in 2000. We looked at all these different models, with adjudication being separate and everything else. Inevitably, we agreed with some and not to others. This is one with which we did not agree at the time. We always felt that Council members had to have control in fitness to practise areas. That has proved not to be the case in the last 12 months. It was probably very lucky that the experience of some Council members went to the associate members’ group, where they played leading roles. That is how I see the future, certainly for fitness to practise.

Screening, which was done by members of Council, including members sitting round this table, has now gone to case workers. No complaints have come back to me about that. I think that it is inevitable that we will not be in a position to sit on investigation committees as members of this Council. In my view, it would be healthier if we did not. These are decisions that are difficult to make on occasions, but I think that the experience of the last 12 months makes it much easier for me to say that I would be quite prepared to accept this principle now.

I understand what Stephen is saying. To some extent, it is not true to say that we do not sit on fitness to practise committees as such. As far as registration oral hearings are concerned, there is still an element of this, and to some extent we are still doing that on registration committees. That is why I assume this is in two different recommendations. We will need to look at this. One principle will not necessarily bind the other, but I would be quite prepared to accept the principle in the first recommendation. It will be up to the Registration Committee to debate the intricacies of taking it further, and how it will affect not just the committee members but, in particular, the office in the way it presently operates. In terms of major changes, and the doing away with limited registration, the changes will take place in the secretariat. Would that facilitate something like this?

I know that these are issues for the Council. If we do not want to take the decision now and that is the feeling round the table, perhaps we should take decisions on board at the next Council meeting, having given the registration secretariat and the committee the opportunity to debate these issues and to look in detail at what effects they would have.
THE PRESIDENT: I wonder if that is the view of the Council generally. I know that some people feel quite strongly the opposite, but the tenor of the debate seems to be that we should look very much more carefully at separation and probably move in that direction – ask the two committees to have a look at that over the course of the next month, and bring it back to Council as soon as we can. Do people agree with that? Is that for recommendation 2c and 2d? Are people content?

DR JOHN JENKINS: I am content with that, but I wonder whether we also need to keep in mind any possible implications for other areas of Council’s work? For example, education and the QABME process.

THE PRESIDENT: I had not thought – but, yes.

PROFESSOR JAMES DRIFE: I was not going to say anything, but that particular comment was something I was going to say sardonically. I think that a point we should dwell on, before we come back to it at the next Council meeting, is that one of the criticisms about the judiciary is that they are not sufficiently in contact with the real world that others have to live in. It may be an unjustified criticism, but it is a perception.

The comment that you are disbarred from taking part in the Education Committee if you are a medical teacher would seem to me to be the *reductio ad absurdum* of the principle that you do have to be involved in reality to have the insight in order to carry out the governance function. In terms of separation of functions, therefore, the insight that this Council needs into what really happens is very important. That is the point we should be thinking about: how do you make sure that we have the knowledge?

I gather that yesterday’s seminar, which I was not able to attend, was a useful educational experience. That should not be a one-off. All the discussions of Council should be informed by as close contact as possible with the reality of what we are governing. Going too far with the principle of separation of functions, or the governance, is a skill in itself. It means that we would be well qualified here to run BP or the NHS, but not well qualified to look at the realities of medicine. That makes me a little uneasy. I can absolutely see the principle and the need, and it is the mood of the times, but I think that you lose something if you separate too much. That is what we should be thinking about.

THE PRESIDENT: I suspect that you have struck a chord with many people. Coming back to QABME, it is not so much because you are a medical teacher that you would be disbarred; it is because you are a member of Council itself. I wonder if, while we could get the education section to have a look at that, we should limit ourselves to the two casework committees here, and focus on registration and fitness to practise for the moment.

MR FINLAY SCOTT: It seems to me it is not about good versus evil, but about competing goods. Perhaps what Stephen’s remarks and other contributions have suggested is that we do need to take away and reflect more carefully on those competing goods.

The separation of governance from involvement in current casework is a fundamental issue in terms of the effectiveness of governance, and I think that many members have acknowledged that. However, the competing good, which Stephen has alluded to, is that a level of understanding of the processes for which you are responsible may enhance rather than detract from your governance responsibilities. It is how we find a way of reconciling the
competing goods. If you are content to take the President’s suggestion, we will give some further thought to that.

**MRS GILLIAN CAMM:** This tension between being accountable for governance and having a sufficient handle on what is happening on the ground is a common theme in governance. There are all sorts of examples about how organisations and people accountable for governance can stay in touch with that. I think that we should develop a better understanding of how other organisations do it, and bake that into the way we train and develop ourselves.

**THE PRESIDENT:** Would you be willing to feed some of your expertise into the secretariat, so that as we take these things forward we can benefit from that?

**MRS GILLIAM CAMM:** Yes.

**THE PRESIDENT:** Are we content that we will not make a decision today? We will refer it back to these two committees for their views, but it has to come back to Council for a final decision on this. The general direction seems to be to seek appropriate separation wherever we can. Have I got that roughly right? [Agreed] If so, can we move on to recommendation 2e?

**MR PAUL BUCKLEY:** Just before we get to that, President, paragraph 43 picks up the issue of patient and public involvement, which is dealt with in paper 6d. Paragraphs 44 to 46 refer to the issue of accountability and the fact that Dame Janet endorsed our proposal that the GMC should be directly accountable to Parliament and publish an annual report for scrutiny by a select committee. No doubt that will be considered during the review.

Moving on to fitness to practise, as we said earlier, 55 of the recommendations – that is more than half – concern fitness to practise. Dame Janet welcomed the reformed procedures introduced on 1 November 2004, commenting that they are “capable of providing a much-improved method of protecting patients from doctors who might harm them”.

Many of the recommendations that she has made would simply put into rules what is already standard operating procedure set out in guidance. It may be possible that Dame Janet’s entirely legitimate wish to see procedures that are as clear and transparent as possible can be met, but without putting all the operating details into legislation. The recent experience of the Council has been that doing so makes the regulatory framework extremely inflexible and, because the process required to amend legislation is time-consuming and resource-intensive, not just for us but for our colleagues in the Department and for those with whom we consult, the unintended consequence of putting all this detail in legislation can sometimes be that desirable changes are delayed, or even put back for several years. No doubt that will be an issue of principle which will need to be picked up during the review.

Otherwise, there are a great many individual recommendations that require further consideration by the Fitness to Practise Committee. The Fitness to Practise Committee has already begun the task of working through those, and the recommendation is simply to agree that the FPC should carry on with that task and bring back proposals for Council to consider in due course.
THE PRESIDENT: Many of these are enormously technical, of course, and it is easier to have them digested for us than to have a discussion around this table. Are we generally content with this approach?

MR STEPHEN BREARLEY: May I just make an observation? I did not expect to enjoy Dame Janet’s speech last night, but there was one bit of it that I have to say I did enjoy enormously. It was the bit where she seems to be recommending that we should bring back the Blue Book.

She wanted a clear description of the sorts of things that get doctors into trouble with the GMC, combined with a clear description of the processes which would be followed if such cases came to the notice of the GMC. I have commented before about how being on the GMC is a sort of religious experience and you have to have faith in scripture, and the scripture in which you have to believe is of course Good Medical Practice. However, I have to say that I have an agnostic streak in me. I was always slightly uncomfortable with Good Medical Practice, in that it lost some of the very explicit, dogmatic information which was in the old Blue Book.

I wonder if there is not a place for having a recast Blue Book, along with Good Medical Practice – which clearly we would wish to keep. So I was delighted with that bit of Dame Janet’s contribution. It seems to be reflected in paragraph 58 of this paper, and perhaps I could give notice that I would love to be involved in the writing of the Blue Book 2005.

THE PRESIDENT: Can we take the spirit of your remarks rather than having an open debate about whether or not we should go back to the Blue Book, and how much of it we should have today? But making it clearer what we expect of doctors – which is the point of this – must be right.

MS RUTH EVANS: Taking seriously what Stephen said, the GMP review, which is being led by John Jenkins and I, has asked the question about whether we should revert to a prescriptive form of sanctions guidance advice which is like the Blue Book. I think that the consultation findings will show that that is not the appropriate way forward, but there are ways, which we have already started devising, in which you give further and particular advice, through FAQs and so forth. We will report back on that, therefore, and we are actually looking at it.

DR JOAN TROWELL: It will not come as a surprise to any members of the Fitness to Practise Committee if I say at this point that we have given consideration to our thresholds and criteria for decision-making, as we call it. The first draft of this was in place before our case examiners took up their role on 1 November. We are bringing back to the next meeting of the Fitness to Practise Committee a slightly revised and expanded version of this and, at that point, we will be bringing it back to Council again, with the intention that it goes on our website.

So, like so many of the positive recommendations in her report, I feel quite happy to endorse the idea and say that I am very glad that I prepared one of these beforehand – because I should not like to be starting it from scratch now. We will ensure that Stephen receives a copy for consultation. We are delighted to be able to work with you on this one.
THE PRESIDENT: If I can try to get myself out of this quagmire into which I seem to be sinking – are we more or less agreed on recommendation 2e? [Agreed]

That means we are on to recommendation 2f.

MR PAUL BUCKLEY: I do not think that there is a great deal more to add. We have either dealt with the remainder of the paper, or we will be dealing with it in the other papers.

THE PRESIDENT: Finlay, do you want to pick up any of the comments in the last paragraphs, 65 to 75? If not, are we content with recommendation 2f? [Agreed]
3. Chief Executive’s Report

MR FINLAY SCOTT: As usual, I will assume that it has been such a riveting read that you were unable to put it down once you had picked it up, and I therefore do not propose to take you through the report line by line.

An addendum has been tabled. This is about the winter peak, and it gives you some continuing idea of the scale of activity. Secondly, normally at this point in the month I would be able to give you an addendum which reported the financial position at the end of the most recent month; but, for reasons that are to do with the presence of the auditors in connection with the end-of-year accounts, that addendum is being finished even as we speak. That means there are two possibilities. Either I will be able to give it to you before you leave today, or we will post it to you. However, that explains the absence of the absolute up-to-date position.

There is also news which I have not so far managed to share with Graeme – which will come as joy to some and possibly disappointment to others. The May Council meeting was scheduled to be held in Manchester. For reasons that are connected with the increase in staff to accommodate the ever-growing requirement to service fitness to practise, we have a number of colleagues currently camped in the room in Manchester that we would use for the Council meeting. We have looked at a range of Manchester-based options – including renting Old Trafford for the day! – and we have come to the conclusion that the May meeting more sensibly should take place in London. Unless there is acclamation to the contrary, I will assume that you are content with that.

THE PRESIDENT: Are there any questions for Finlay on the report?

MRS FIONA PEEL: There is only one thing about which I wanted to ask a little more, and it is paragraph 27. I find absolutely fascinating the number of applications that our junior doctors have to make before they can get a PRHO post.

Perhaps we might be able to get under some of those figures, because we are recruiting a lot of doctors from abroad and we need to see whether there is a problem there for our medical schools as well – because those headline figures do not tell me all that we need to know.

MR FINLAY SCOTT: Perhaps I have not made it sufficiently clear. The figures are derived from a survey of international medical graduates who pass the PLAB test. They are not derived from UK doctors. That is the point. It ties into the topic we brought to Council last year. There is currently a problem in matching the supply of doctors who have passed the PLAB test with the demand for doctors to fill training grade posts.

Because of that growing concern, we have taken a number of steps. One was to try to understand the nature and scale of the problem, and the survey is part of that. Second, to ensure that international medical graduates have the best information we can provide before they commit themselves to coming to the UK to take the test and seek employment. Third, to try to work with the Departments of Health, but principally the Department of Health for
England, to ensure that there is, in a more general sense, better information available about job prospects and better systems for matching doctors who want a post with available posts.

If it is not clear that it is about international medical graduates, I apologise. I do not think that diminishes the force of the point, which is that there is something not quite right about the system at the moment, and we will continue to work with others on that.

THE PRESIDENT: There is some preliminary evidence that the information we have been getting out into the overseas market, if that is the right word, about jobs in this country is beginning to have some effect. Amanda will keep me right here, but I think that the number of applications to sit the PLAB test in India in November was down by 37 per cent. So there is some evidence that this is beginning to correct itself, now that information is more readily available.

MRS FIONA PEEL: I am interested because of some of the work that the Education Committee is doing at the moment about the globalisation of education. This will be an important feature in it.

PROFESSOR CHRIS BULSTRODE: It may not be relevant to say this at this point, but I think that it also frankly inhuman and most unprofessional to treat black doctors in this way. Part of the reason is that they are applying for jobs which they have not the slightest prospect of getting. They are not getting career advice or clarity in the job application. I know that it is not our responsibility, but it is certainly very tough on them when they are trying to make their way in a new country, and are being no guidance whatsoever on how to get started.

THE PRESIDENT: I think that we are a willing participant. We need to play our role in that and not stand aside from it.

DR JOHN JENKINS: My comments relate to the disparity that these figures show in relation to the different devolved nations of the UK, and particularly Northern Ireland. Discussions are taking place with the four Departments of Health, and I am sure that our Department of Health would be very interested in any way in which we can make it clear to doctors that, by and large, there are jobs available in Northern Ireland. Perhaps the Northern Ireland Tourist Board might even….!

THE PRESIDENT: I will have a word!

DR RACHEL ANGUS: I would just point out that this document is on the website in its entirety, and would be accessible therefore from far-flung parts of the world.

MR FINLAY SCOTT: Amanda is very happy to talk about this after the meeting or subsequently, but in effect you cannot get to the bits of the registration website that international medical graduates want to get to without confirming that you have read the information that we provide about the risks they have to weigh up. So we do our very best to ensure that they have access to information.
You may recall that this was a feature on a Newsnight programme in the late autumn. When the programme was being prepared, it was being prepared on the basis that it would be anti-GMC for creating a problem. In fact, by the time it was broadcast, it had taken a rather different slant. John Hutton, as the minister of state, generously acknowledged that the issue was not the GMC but the availability of information to enable highly educated, hardworking, willing professionals to make sensible decisions in the context of information. That is what is missing at the moment – the information.

PROFESSOR WENDY SAVAGE: I was interested in the pre-registration scheme for students on paragraph 20. Is there a danger here in that, if a doctor fails, how do we make sure that they do not go on to be properly registered?

MR FINLAY SCOTT: Perhaps Amanda could answer this, rather than my acting as her mouthpiece.

MS AMANDA WATSON: What we have been piloting is a programme of ensuring that we can allow UK graduates to register as swiftly as possible after they have graduated. So we go and collect some pre-registration information about them, including their photographs and doing their identify checks when they are in their final year. We record that; we give them a GMC reference number, a PIN and a password. When they have graduated and we have the sealed list, they are invited to apply. They then apply electronically.

So although we set a record up for them, they are not, as it were, registered in the Medical Act sense of the word. We just have a record ready for them so that, when they come to apply, they can do so. If they did not graduate they would not be able to apply, because their name will not be on the sealed list of the university.
4. Developing Medical Regulation

4a. Working towards a patient and public involvement strategy

4b. Improving access to information about doctors

4c. Developing a risk-based approach to regulation: the early identification of impairment

4. Developing Medical Regulation

4a. Working towards a patient and public involvement strategy

THE PRESIDENT: Are you happy to speak to us first, Harry?

MR HARRY CAYTON: May I thank the Council for inviting me? I have had a number of meetings with Council officials over the last few years on different issues, and I have always found them very straightforward to work with and very helpful, and I have met with Sophia and others quite recently to discuss this paper.

Perhaps I might give a general introduction to some of the issues from my perspective, and what I think you need to be thinking about as a Council in order to develop the kind of strategy that will be useful to you and fit for purpose. More than anything, I am not interested in patient and public involvement as an end in itself, because I do not think that it is an end in itself. I think that it is a means to an end, and the most general end is clearly the improvement of healthcare and the improvement of individual health. In that sense it has a real relevance to the GMC, but finding the way in which the GMC could do that effectively and efficiently requires some reasonable thought.

If I said to you that, from my point of view, the purpose of patient and public involvement is to provide surprises, you might be surprised. However, what is it for if it is not to widen our perspectives, bring different expertise, to approach a problem from a different angle, and maybe sometimes to provide a solution so simple and so obvious that, as professionals, we could not see it at all.

I will give you a very slight example to make that point. In one hospital there was a pulmonary rehab clinic, which the people running the service were very pleased with; the patients came to one session of pulmonary rehab and gave all indications of finding it helpful, but they did not come back. They wisely decided to ask the patients what they thought of the pulmonary rehab clinic. The patients said, “It’s terrific. It’s really good”. In some parts of the NHS they would have stopped at that point and said, “We’re running a great clinic. It’s clearly the patients’ fault. They are quite stupid – they don’t come back. But they have told us it is a good clinic; we know it is a good clinic. So there’s nothing we can do about it”.

Fortunately, they went a step further and said, “Why don’t you come back if you think it is so good?”, and the patients said, “It’s the buses. The clinic ends at half-past three. We are elderly and puffed and not very good on our feet, and we have to go home on a bus with all the schoolchildren. It is so awful that we don’t want to do it. When we think about coming to the rehab clinic, we think ‘I’m not going to go to that. I’ve got to go home on a bus at half-past three, and it will be awful’”. All they did was to move the clinic an hour, so that it finished at
half-past two instead of half-past three. The patients then turned up for their repeat sessions and they got the health outcomes they needed.

It is such a low-level kind of engagement that it is perhaps not relevant to the big strategic work that the GMC has to do; but it seems to me to illustrate my point that, by engaging patients appropriately, we get solutions to issues – as well as helping to identify problems.

How does it have relevance for the GMC and its role as a regulator, a professional standard-setter, and a public guardian of medical standards? First, and obviously, it is patients that need the GMC to exist and to fulfil its role. Patients with serious complaints, such as those who come to the GMC, need justice as much as accused doctors do.

Secondly, the public needs to have confidence in the GMC as a guardian of standards on behalf of all of us. Justice, as the cliché has it, needs to be seen to be done, but I think that you need to remember that in these circumstances doctors are always seen – perhaps incorrectly – as the powerful against the powerless. I think that colours the difficulty that the GMC has in explaining its role to the public.

To my mind, therefore, your patient and public involvement strategy needs to differentiate quite clearly between respecting and involving patient perspectives and expectations, and the task of understanding and safeguarding the public interest. So patient perspectives and the public interest are two sides of the same coin but they are different things and they have different roles to play in your deliberations and in your work.

For you, a good strategy will be clear about what you need to achieve in each of those separate areas: when you need a patient perspective and when you need to understand an individual patient’s view; when you need a public perspective and when you need to understand what the public wants and needs from you.

As the paper you have before you this afternoon says well, different methods of involvement and engagement are appropriate for different tasks. The one thing I urge you strongly not to do is to set up a patient advisory group. A simple opinion poll might tell you what the public thinks of the GMC in a broad sense, but it will not tell you how to change that perception. A focus group might take you further in understanding the underlying reasons for people’s views. A citizens’ jury might help to give an informed and balanced judgment on a difficult issue. Individual patients or representatives of the public – as I know many of you are – can bring a broader, long-term perspective by taking an active role in committees, as that is relevant.

The paper that you have today begins to address these issues, but your strategy in the longer term needs to identify the roles and processes of the GMC and what is the appropriate contribution of the user perspective to those particular roles and processes. The paper probably needs to do a bit more to clarify the difference between the public interest that all of us have as citizens in effective regulation and a safe, well-conducted medical profession, and our individual patient interest in personal care and quality of treatment.

One example that occurred to me about where I think the public perspective might be helpful arose from a conversation I had with a friend, who happens to be a former member of this body. They said to me – and I have to say they clearly were expressing a personal view here – one of the things that perhaps the GMC had to, ought to, take into account when deciding appropriate action in relation to a doctor’s fitness to practise would be whether, by being over-zealous, they were getting rid of potentially good doctors from the service, and therefore, as it were, damaging the public interest by reducing the supply of doctors.

I do not think that I know the answer to this, but that seems to me to be quite an interesting question. Is it the role of the GMC in any way to maintain the supply of doctors? Or is that irrelevant to the GMC’s role of maintaining the quality of doctors? I do not think I know the answer to that. There may be an entirely legitimate public interest in a reasonably adequately staffed health service, full of reasonably competent people; but it seems to me that is exactly
the kind of issue where a greater involvement with the public would help you to decide whether indeed those were appropriate values for the GMC to have.

To conclude, I would like to make a few particular suggestions. First of all, information and communications are a fundamental part of both patient and public involvement, and an active, outward-looking communications strategy that really engages with what patients and the public need is very important. You will be aware that many people who try to use the GMC website do not find that it provides them readily with the kind of information they think they want from it.

Secondly, when you are involving lay people in these sometimes quite difficult issues and committees, you do need to support and resource the support for them. So giving people confidence to make a valuable contribution and allowing them to make the contribution they can, where they may well not be as experienced as you are in these kinds of very formal meetings, is a very important part of making it work.

There are usually three perceived problems with patient and public involvement. I will just raise them briefly, and I am happy to discuss these afterwards. The first is competence. How can these lay people be competent to deal with these complex issues? My answer to that, first and foremost, would be that you are looking for perspectives and points of view. You are not necessarily looking for the same standard of competence that you would legitimately expect of formal members of the GMC. You would be astonished at the range of skills and talents that people can have and can demonstrate, if they are given a proper opportunity to do so. Secondly, there is a view – or can be a view – that patients and the public are biased; that they somehow are subjective or more subjective than other groups of people. Again, that is probably sometimes the case. It is only a matter of being sure when you are looking for a subjective point of view, which you are going to mediate and understand, or when you are looking for a more objective point of view – in which case asking one individual. I may be the National Director for Patients, but I never ever express a view on behalf of patients. I would always say there are patient voices and my role is to facilitate our ability to listen to those voices. I certainly do not speak for them.

The third is a great red herring, and that is the idea of representativeness. You will not get it; it does not exist. So the objective is to get a range of perspectives and to have those insights, that competence and that expertise brought into your discussions, in the same way as you do now. Many of you will have skills and will have some knowledge of the profession, or the bit of the profession, or the background that you come from; but, in the end, you are here as individuals, not as representatives. I think that representativeness is often a red herring in arguments about this.

Finally, the qualities that I would want to look for – and I believe that the GMC has many of these qualities but does not wear them on its sleeve perhaps as vigorously as it might – are a sense of high quality, justice, credibility, consistency, openness and humanity. I would extend that humanity – and I believe the public would, if properly understood – to a judgment of concern and care both for the well-being of doctors and for the well-being of patients. I believe that, well explained, the public would be perfectly happy with that. I do not think that the public have a narrow view of these things. I think that they often get a distorted view from the limited information that they are given – particularly, of course, from the press.

My own experience is that if you really intend to involve the patients and the public – and I would say that you really have to have that intent – have clear objectives, use the right methods, and provide adequate resources, you will find that their perspectives can be both more surprising and wiser than you had ever expected.

THE PRESIDENT: Thank you for that, Harry. That is a very helpful and enormously comprehensive overview. I doubt if anyone round this table would disagree with one word you have said. Doing it, of course, is another issue. We are intent and we will do it. It is very helpful to have you here.
I wonder if we should divide this into two parts. If there are issues about what Harry has said, let us take them now.

**MS RUTH EVANS:** I totally agree with almost every word Harry has said, and I would like us to develop further the examples in this paper.

**THE PRESIDENT:** I like that word “almost”! Is it best then to move on to the paper itself?

**MR KEVIN BARRON:** I completely agree with what Harry has said about representativeness. This has been part of my portfolio for 15 months or more. We do have a Patient and Public Reference Group, which could possibly be this advisory group that Harry advised us not to have! This paper goes far beyond that, and I will let Sophia to go into the detail of it.

However, representativeness is something that you cannot get. I remember that, when Brian (Keighley) and I were looking at this Council’s representativeness, it would have had to go from 104 to something like 800 if we wanted it to be representative! We did not go that way.

Harry has put his finger on most of the issues. I would say to Council members that they should look, not so much at the actual paper, which Sophia will go through, but at 11 and 12 in the aims and objectives and what we are trying to do. We have there the issue of the general public and patients and, as Harry rightly points out, they are not necessarily the same, and it is something we should look at rather differently in future.

I will hand over to Sophia, who has been working on this paper and having discussions with many people since we last discussed this in November.

**MS SOPHIA BHATTI:** In the paper presented previously, Council highlighted the importance of working closely with a wide range of partners and interest groups on taking forward regulation. The paper before you today highlights a target group, that being patients and the public, and how we as a Council establish an effective and efficient relationship and partnership with those groups.

Let us not forget that there have been extensive developments in the realm of patient and public involvement, and the strategy reiterates that. For example, the reconstitution of the Council itself was a fundamental reform which considerably increased lay membership and lay input in our decision-making. The draft strategy is based upon the framework which we discussed in January, and I understand that there was general agreement.

As Harry has mentioned, we felt that it was absolutely vital that we did not hinge our attempts to achieve effective patient and public involvement on just one or two key mechanisms. Therefore, the strategy develops a number of possible mechanisms that we could take forward. At this point it is probably worth highlighting the fact that this is a pilot strategy. The reason why we have opted to undertake a pilot during 2005 is because this is a very complex issue; we have some very complex target groups with which we need to engage effectively; and we are the first to acknowledge that we do not know exactly how to do this. We do not have all the answers at the moment. The best way to put together a programme which is effective and efficient, we feel, is to roll out a pilot that will allow us to test some of these mechanisms, but which will also give people the opportunity consult with us and give us their views as to how they wish to be engaged, and on what issues they would like to be engaged.
I am sure that there are some issues that a lot of people would rather not engage with at all – but we are not in a position to assume what those issues might be.

The strategy therefore allows us, during 2005, to test a number of mechanisms. You will see in the paper a number of recommendations, and commitments either to scope or put in place a number of options during the course of the year.

Kevin has already highlighted the aims of the strategy, so I will not reiterate them. The framework is based upon what we discussed in January: that is, we will have a number of engagement mechanisms, underpinned by implementation mechanisms. The theory there is that we could have a whole host of very effective engagement mechanisms but, unless we ensure that we have effective ways in which to bring the insight and the information we gain at stage 1 – i.e. engagement – and ensure that is brought within the policymaking of our organisation, we could regard the rest as pointless.

There is a chapter in the pilot strategy, therefore, which allows us to test again – the emphasis being on “test” – a number of mechanisms by which we will see how this works; how we bring patient and public involvement into our policymaking.

Finally, a review and evaluation. I say “finally”, but it is not the least important. You will note that I have presented the pilot and a strategy going forward from that, as a cyclical process – which I believe it ought to be – but with review and evaluation being the final limb. Essentially, in the pilot year those will probably be the most important limb of our work, which is to step back and assess what has and what has not worked; how much patient and public involvement has impacted upon our policymaking; and is that in line with our stated objectives? Again, the paper outlines a number of commitments as to how we may go about developing those mechanisms.

I will leave it there and allow Council to pose questions as they will.

**THE PRESIDENT:** It is critically important to our work, for a variety of reasons. While I think that we have strengthened our relationship with the profession in recent months, and perhaps years, I am not at all sure we have got this fixed at the present time. So implementing or developing or amending this is absolutely important to us, particularly at the present time.

Are there comments either on the overarching paper or on the strategy which is Annex A to the paper?

**PROFESSOR WENDY SAVAGE:** I am a bit slow today, because what I have is a question for Harry. Why do you not think that we should set up a patient advisory group?

**MR HARRY CAYTON:** What I am really saying is do not set up a patient advisory group and think that has cracked it. If you know what the role of the patient advisory group is, on what it is going to advise you, what you are going to do with that advice, and what difference it will make to your organisation, then that is fine. However, so often I see organisations who say, “We had better do something about this, so we will set up a patient advisory group”. Then they do not know what to do with it, and neither does the advisory group know what its role is. It gives advice, nothing much seems to happen, and the members drift away.

I am being slightly facetious, therefore, when I say do not do that; but I am saying that there are many ways of engaging people in your work, helping people to understand your work, and helping their insights to enhance your work, without having a committee.
THE PRESIDENT: When this topic was last discussed here, that issue was raised very clearly. I think that Council members here want to be absolutely sure that what was being proposed came back to the Council table itself, so that the Council members both understood what was happening and could drive it forward.

The concept that we could park this on to some kind of advisory group and just let it be hived off in the way you describe was something that we were very much opposed to at that time – and I guess still are.

MS RUTH EVANS: I wholeheartedly agree with what Harry said. In fact, as you may know we have difficulty ourselves in the group that we have – the Patient Reference Group – in trying to get roles properly defined, and being able to use that group and allow them to have input in a way which will be mutually beneficial. It is a real problem.

Turning to the paper, I may well be echoing some of the meaning behind Harry’s statements in looking at the aims and objectives. There is a huge amount of useful stuff in this. I think that there is one area in which I would hope that we would be able to develop the work more – not in a functional way, but in the aims and objectives and the overriding philosophy. That is the bit we are missing from this paper.

It may be because we all think we know what patient and public involvement is for; but it is very complex, as you have said, and it is a very difficult issue to articulate. When we say, for instance, under (a) of Aims and Objectives that we want to obtain “a better understanding of patients’ and the public’s expectations of regulation”, I am not sure that should be what we want. I think that we want a better understanding of the patients’ and the public’s views of Good Medical Practice. We do not need to get from them an understanding of regulation; it is Good Medical Practice. It is what, in the patients’ view and in the public’s view, are the core elements of the document that we have and all the guidance that emanates from the standards set by that document.

When we say that there is “Provision of a better quality of service”, what sort of service are we talking about? Are we talking about doctors’ service or the GMC as a regulator, or the GMC in setting standards and ensuring that those standards are maintained?

We ought to be stating at the beginning why it is important for us to involve the public and patients in the work of the GMC, which is a professionally led regulator with a medical majority. And what does that mean in terms of involvement of patients? I have to say that my own background, many years ago, was in maternity services and mental health services. In my earliest days, it is fitting to pay tribute here to Wendy – who, in her clinical practice, did really show the world, often to her colleagues’ consternation, what patients wanted and how this could be delivered. In those early days – this was in the Eighties – we know what happened to Wendy, but she led a movement of women who said they wanted maternity services to be delivered in a way that did not just improve the happiness and so forth of the women, but actually influenced health outcomes, morbidity and mortality rates.

Wendy pioneered this, and we have to encapsulate within a document like this the nuts and bolts of what we are talking about. What is patient and public involvement, why is it a matter for the GMC, and what can it do to improve health outcomes as well as satisfaction and partnership in the delivery of care?

Once we have got that bit done, I think that we then need to look, as we have done in this document, at the functions of the GMC and how that philosophy can translate into real improvements – whether it is through setting standards, revalidation, fitness to practise – and then how we are going to deliver it. As Harry said and as the paper says, there are many different methods of consultation, and not one on its own should be used. You always require a multiplicity of purposes, whether it is a MORI poll, a focus group, a citizens’ jury, whatever it
is. Look at what you need to find out, but do not rely on a particular method of consultation for the final answer.

One of the methods that we can employ is the people round the Council table itself, and they are not included in this, funny enough. The Patient Reference Group is. It goes back, if I dare, to yesterday’s discussion. Council members, both doctors and lay members – those of us who have experience in involving patients and public – should be used more. We ought to be seeking from our members that sort of direct experience – of those who, at the clinic or in other ways, through voluntary work, through endeavour, whether lay or doctor, actually have involvement with patients and public, and what that means. I think that would be very helpful.

We have got a long way down the road, but I think that we need to have a discussion about what the objectives are, what the philosophy behind it is, and from that will flow a lot of good work.

THE PRESIDENT: Can I take you back to the beginning, when you said that you did not think we should be concentrating on medical regulation? Setting aside the fact that it is a clumsy term, and I very much understand that, I would have thought that we did want to involve patients on broader issues than just Good Medical Practice. Their views on medical education, on fitness to practise, on revalidation, seem to me to be just as important as being on standards.

MS RUTH EVANS: Thank you for raising that. That is not what I am saying. It is item (a), as it is currently worded, “Obtaining a better understanding of patients’ and the public’s expectations of regulation”. I suspect that they have very few expectations of regulation.

THE PRESIDENT: Yes, but the point I am making badly is that I am not sure that I want it honed down just to Good Medical Practice. It seems to me there are broader issues that we deal with, in which the public ought to have greater involvement.

MS RUTH EVANS: As I said, all of our activities, including education, standard-setting, and revalidation.

There is one final point I would like to make, which is a very small point. The PRG pre-existed the revalidation work, although it says that it was set up for the purpose of revalidation. It was not. That appears on page A7 in the third paragraph. Maybe I misread it.

MR KEVIN BARRON: That was my understanding of it when I inherited it in July of last year or the year before. I understood that was why it was set up – for the purposes of revalidation and only that.

Council members will remember what I told you last time I spoke on this in Council: that what we do is get the papers from Council, what is on your agenda – not all, but some. We drop the papers in front of them and everyone looks at them and says, “What do we do with this?”. That is the truth of it.

I understand why you are saying some of these things. I think that it is very important that people should understand about medical regulation. As I understand it, that is what the General Medical Council is about. There are issues about standards and everything else, but there are other organisations that handle them for and on behalf of the people of this nation.
It is said that Council members are not involved. This is the second or third draft that you have had. We want you to be involved. Indeed, Council members are working with Sophia on this issue. Besides the PPRG, people are involved in that. We come here and we want your involvement in it.

As Sophia said, this is a pilot project. There is a long way to go on it. I would say to you, as chair of the PPRG, I am not satisfied that it is playing a useful role in our work. Harry has alluded to this. You cannot just have something where it is, “That’s where you talk about patients and the public” and stick papers in front of them, with nothing to do. All they do is look at them and say, “We’re very impressed with that. We’ll see you in a couple of months’ time.” That has to stop.

THE PRESIDENT: If that is all we do, it simply duplicates our function. We need to move on from that, therefore.

MRS FIONA PEEL: We do have a PPRG and we have to make it work. We have not even written the terms of reference here. Some of Ruth’s comments could be incorporated into those terms of reference.

Reading this paper and hearing Harry’s comment – and it is something I discussed with Sophia earlier – it has put much more clearly into perspective for me this differentiation between “patient” and “public”, and looking at the conflict of interest between the patient and the public. We may be able to begin to focus on our priority groups a little more effectively, and cluster them into patient-based ones and public interest-based ones. We may then be able to set the right tasks for both of the groups, making sure that we see where the conflicts lie.

We can probably develop that through the PPRG as a route – because they will become a sort of filter route, I would guess, at some point for doing that. As it stands at the moment, our target groups are too wide. We cannot cover all of those, so we will need to set some priorities.

MRS ANN ROBINSON: I think that this draft strategy is a pretty good one. We may want to tinker with one or two bits of it, but I think that it is the right approach.

I just want to make a couple of points. First of all, the point that Ruth raised and which you commented on, Graeme. It is the issue about the public’s expectations of regulation. I think that is a really big question and it does cover what we should be doing in all aspects of our work. It will be terribly difficult to get at, and I hope that the combined efforts of the Department plus the work that we shall be doing in our tracking survey will at least begin to uncover some of that – but it will not be easy. However, we have to know what they think we ought to be doing, as part of our overall approach.

The second thing to say – this sounds like a criticism though it is not meant to be, but I am part of the Council and have a responsibility too – is that maybe we ought to spend a little more time about what aspects of particular issues we ought to be engaging the public in. It will not be everything. Simply putting the papers in front of a reference group is not good enough. We have to have some clarity about why we are going there and why we think that – and that is hard. I think that we have more to do in how we handle consultation generally. We tend to take a broad-brush approach, that everybody is interested in all of it. Quite frankly, they are not. With some audiences, we have to work a bit harder at extracting the right kind of information.
Thirdly, I completely welcome what Harry said about the public and patients. I fought quite hard right at the very beginning to get people to recognise that there is a public interest as well as a patient interest, because originally we called it a Patient Reference Group. We did not put the word “Public” in for a while. I think that they are two different things. When it comes to the “patient” bit of it, the major interests will be in relation to complaints; how to handle them; what they should complain about. It is what is happening to them.

I agree with Harry that the public aspect relates to how we are doing as a regulator, and whether or not we serving the public interest. They are entirely different things. One is the generality of what we do, how we do it and whether we are meeting their needs. The other is people’s own personal experience, when they have a right to be concerned and a right to have redress. I therefore think that this is a really helpful discussion.

PROFESSOR CHRIS BULSTRODE: I am just a tiny bit puzzled, and perhaps I could have some clarity on this. This paper is entitled Patient and Public Involvement Strategy. I can understand the traffic of information in one direction, from the patients and the public to us, to advise us on what we should be doing and how we are perceived. What I was hearing from some of the speakers was information going in the other direction: that we were somehow to be informing the public about what our job was.

I am not at all clear that this is a useful route, but maybe you could clarify that. It seems to me there are other routes that you can go. If you want to inform the public and patients what the GMC does, there is not much point in talking to a small group of individuals who have kindly turned up for the afternoon. Have I misunderstood that?

MR KEVIN BARRON: No, I do not think you have. If you look at the breadth of this pilot project, we are looking at other routes. It seems to me that they are big issues. This is a good discussion, because it is a bit broader than those we have had in the past. It has been passing papers which we felt were relevant down to a group of people who represent the people who are in the room at the time. That is not to talk disparagingly about them. Some of them are there with good intent, as it were, but I am not sure where it is going.

PROFESSOR JAMES DRIFE: Just a couple of thoughts from the perspective of the Consumers’ Forum at the RCOG. One is the difference of the GMC compared to what you require from a specific service or from a specific specialty. One of the assumptions we have made is that, because of lay representation, that represents public involvement and we have got past that. The other is the huge diversity of what we do, but it is not focused on an area on which it is very easy to get a consumer view – because it is so broad.

It is a challenge to us, I guess, to be able to tailor patient and public involvement to our particular needs: unlike the RCOG, where we have assumed that our Consumers’ Forum would consist of women. Just thinking about it, that was perhaps an inadequate assumption. Maybe we have a broader remit. Anyway, that is an example.

The experience we had from starting off with the Consumers’ Forum was that initially it was bolted on; it was politically correct, and did not have a huge influence. Papers were passed to it at a very late stage in their development – “We had better check what the Consumers’ Forum thinks of this”. That was corrected, of course, by the feedback from the forum saying, “It’s not much good your giving us a draft that is just about to go to council. We should be much more involved in the initial discussions of policy”.

The other matter was about the chairing of the group. It was initially chaired by a college officer. I was one of the chairmen. As the group matured in terms of its involvement with the college, it became clear that it was more appropriate to have one of the lay people chairing.
The advantage of having a college officer as chair was that the feedback from the group would go straight back to the centre of the organisation and it would be discussed at a high level. If the group is not chaired by such a person, then the chair of the forum, as it was for us, became a member of council – as many colleges have. So you have that kind of input from the group directly into the deliberations of the council. Maybe it would be appropriate to think about that, as the stages that the group went through – specifically thinking about it as a group rather than as the wider process that we are talking about.

The third and last thing to mention is the overload. Even a royal college produces an awful lot of paper and there are a lot of initiatives going on. A group has only a certain number of people and a certain amount of time that it can devote to it. The question that we reacted to, therefore – “Everything should go to the Consumers’ Forum at an early stage” – would mean an avalanche of material which the group cannot cope with. It has been running for a decade or so, and it has gone through this learning process about how best to manage it, specifically for that college. I guess that it will be the same with our process. This is the first stage of quite a long journey.

**THE PRESIDENT:** There are two things. One is that it is a pilot project, and presumably we should seek to learn from that experience. Secondly, if there is information from your college, or indeed from anywhere else, we should be a learning organisation and take it on board. If you can give that to Sophia, it would be very helpful.

**MR BOB NICHOLLS:** Quite often in these things it is not good enough to set up a group or to say that we have ticked the box because we have, in this case, a Patient and Public Reference Group. It seems to me it is a two-way traffic and we are not using it enough.

I have had a recent experience on behalf of a sub-committee of Standards, and you could say, “Management guidance for doctors? Relationship with patients? Would they be interested?” We had quite a struggle to find anybody to come and work with us at the preliminary stage, which I do think is the right stage to get involvement.

There are two practical things which are not mentioned in the paper. One is that we perhaps need some sort of special interest register. They will not all be interested in everything, but if we had some who would be interested in these sorts of topics then we could begin to have a pool. That would have two advantages. We could get them involved, but also we could use them to reach their networks. I think that is hugely important. It is here in one of the objectives about explaining what we do. I have just come from a lunch where there were, you would have thought, quite well informed members of the public – not immediately patients – who really have no clue about what we do.

**THE PRESIDENT:** Were you lunching here?

**MR BOB NICHOLLS:** No, I went away for my lunch! We need all the avenues we can get to bigger networks out there, about what we do and how we do it – and get that feedback.

The other thing that is not mentioned – although I think that Harry mentioned it – was the media. I do not mean just the press an dour press relations, which I think have improved; but using the media proactively – magazines programmes, TV – again, about what we do, but also being much more open about getting ideas in. “What do you expect from your doctor?” type of thing.
I think that there are other ways of engaging. I am being very sympathetic to Kevin and saying that it is no good our just putting papers before this group; we want it to be much more ongoing and proactive.

SIR ALAN CRAFT: All of the royal colleges now have patients’ and carers’ groups of one sort of another. They all meet together under the auspices of the Academy’s patients’ and carers’ group, which is chaired by Patricia Wilkie, who I think is a GMC associate. I think there would be some value in linking with that group to share ideas.

DR ALEX FREEMAN: I am quite keen for us to move away from this handing things down and asking a group of – without meaning to be rude – almost self-selected expert public involvement-type people to comment on things that we would like to do. I would like to know how we are going to be able to engage the groups that are traditionally under-represented in terms of public and patient involvement – what we would call the minority groups of people, perhaps with communication difficulties.

I would like to see them telling us what they think our role is; what their understanding of our role is; and what we can do to help the public ensure that we can fulfil our role more effectively in terms of dealing with the public. It is quite difficult to engage these groups, but I am very keen that we have a bottom-up approach rather than top-down. We can all sit and have wonderful discussions, based on our knowledge of the relevant legislation and so on, but an ordinary member of public, if you ask “What does the GMC do?” will say that the GMC does not strike off enough doctors. That would probably be the headline view they would have.

I am very keen on getting a better understanding from groups which traditionally have not had much of a voice about what they see we ought to be doing, in order to fulfil our overall aims.

MR STUART HEATHERINGTON: Right at the very end of his presentation, Harry threw down a bit of a challenge, I felt, when he said that the GMC as a Council must have the intent of patient and public involvement.

When I look at the bottom page A8, where it talks about success criteria, I wonder whether we could do worse than to take four of the points that Harry made as success criteria. That is, at the end of the preliminary assessment, have we demonstrated intent? Have we taken the patient perspective that he talked about? Have we looked at the public viewpoint? And, a point that we have not talked about very much, have we provided the appropriate level of support and resource to the group?

THE PRESIDENT: Sophia, do you want to respond to that and to the question that Alex raised?

MS SOPHIA BHATTI: First, Alex’s point about the social exclusion groups or particularly vulnerable groups in society. It is something that we are very aware of. It is something that is referred to in the paper and which we absolutely accept. This is not just a group. There are multitudes of groups. For example, young healthy adults are quite a difficult group to engage with, as BME groups in Leicester may be. Therefore, we are live to the issue. We accept that it will be difficult.
The theory being – I do not know if this is the answer and this is why essentially this is a pilot – that a mechanism which uses just an advisory group, for example, would not in any way engage those particular communities. However, we are trying to implement a strategy that relies upon a number of strings – so perhaps focus groups in the local community. Say, for example, you wanted the perspective of Asian women, you would not call them to a conference, but what you might be able to have is a women-only focus group in their local community, facilitated by or in conjunction with a local community leader. It would be thinking on our feet and using our initiative to home in on these things. We may have successes but I suspect that during our first pilot year we will also fail. However, the principle is that we should learn from that process and filter out those mechanisms which have worked and disregard those that do not, then identify the gaps and relearn.

Returning to the point about linking in with existing patient and public involvement groups, that in itself is one way in which we try to ensure that our mechanisms of engagement are effective – because it has been tried and tested by other people. Let us see if we can learn from those organisations.

Partnership is a real key of the pilot strategy. We accept that we are not the only people trying to do this. We acknowledge that there are many organisations investing in this work. Let us learn from one another and contribute back to the communal pot. In some instances, we could work together. The joint UK Health and Social Care Regulators patient and public involvement group is an example of that. It is something that could translate to other initiatives, such as the single portal for example.

Touching on Fiona’s point regarding the listed target groups being quite broad, I wholly accept that as a very valid point. What I hope we can achieve during this 2005 pilot year is the ability intelligently to focus our resources. I am working on the basis that we cannot assume which of our sub-categories of target groups we ought to be focusing on at the moment, because we are basing that on assumptions as opposed to evidence.

Finally, assessment criteria – I think that is a jolly good idea!

THE PRESIDENT: My feeling of the Council’s view is that, with the comments that have been made here, there is enormous support for this pilot to be taken forward. And – it is not a “but”, it is an “and” – we want to hear how that is progressing, on a fairly regular basis, throughout the Council. Is that a general view? [Several members: Yes]

I will come back to Harry for the last word – the man from the ministry. How are we doing, Harry?

MR HARRY CAYTON: I want to pick up Bob’s point. I think that it is a good idea – and the paper does this to some extent – to move upstream, so that, instead of people being expected to look at papers that you have written, people should be helping to inform those papers before they are written.

Secondly – and I think you do have this – you need to be clear that this is about improving the basis on which you make judgments, not replacing your judgments with the judgments of either patients or the public. I think that is very important. This is about improving the quality of information and evidence on which the Council can operate.

Thirdly, for all the honesty, I do hear some seriousness of discussion and intent, and to be resolute – but do not beat yourselves up, because there are plenty of other people who will do that for you!

On hard-to-reach groups, they are not anything like as hard to reach as we think. It is just that our arms are too short. There are lots of people out there who are quite expert now at
doing this and helping you do it. You might think seriously about engaging some critical friend, hand-holding consultancy perhaps, through this process, from some people who are now really quite expert in getting public involvement and working with minorities. There are a lot of minority ethnic health groups; there are people with a learning disability, and so on, whom you may wish to engage with.

Finally, you are clearly starting on a journey and I hope that when you get there you will be surprised.

THE PRESIDENT: Thank you very much. Thank you for your time and your contribution. I know that you have seen the papers from the other parts of this agenda item. You are very welcome to stay, but if you felt the need to beetle off, we would fully understand.

MR HARRY CAYTON: I have to be back for another meeting, but I would be very happy if you wanted to seek my comments.

THE PRESIDENT: If you are willing, we will keep you informed and seek your views as the time passes on the developments from this.

4b. Improving access to information about doctors

THE PRESIDENT: If colleagues are content, can we move on to item 4b, which is all about improving access to information about doctors. It builds on some of the discussions that we had earlier this year. Again, I suppose it links back to the discussion we had yesterday afternoon about gaining access to the information base and having it in a tiered way – much as we saw on the demonstration for the strategic application process this morning.

MS AMANDA WATSON: This item emerges from a number of discussions and work that has been ongoing around the issue of disclosing information about doctors.

There are three sections in the Medical Act that govern what we hold and how we publish it. Section 30 says what must be in the thing that is described as the Medical Register, which once upon a time was literally a book and which is now a computer system. Then there is another section of the Medical Act, section 34, which deals with what you publish. So once upon a time, on 1 January every year, we were required to publish the Medical Register. We used to print a red book. It was never available until April of the year, so it was always at least three months out of date, and then would be presented again the next year, and people used to buy these volumes of the red book. It now runs to about four volumes.

The critical change was made for us in the Section 60 Order in 2002, which was to suggest that we would no longer need to publish the red book. We could publish the register in a virtual, electronic form, essentially over the internet.

The third bit of the Medical Act which I will mention briefly is section 35B. That concerns disclosure about investigations. There are areas of discretion there and areas where the Fitness to Practise Committee has made policy decisions about disclosure.

In conjunction with work that we were doing to introduce a new licence to practise, the Registration Committee has been working on a new model for registration. We recognised the need to move away from the published red book. We wanted in the future to see
information published on-line via the GMC’s website and that that information could be made real-time and given much wider access.

We also contemplated the need to have a tiered approach to this information, and we said that there would be four levels of information. The first level would be information that would be made available to all enquirers: the doctor’s name, any former name, GMC reference number, and so on. There would then be some information which would be disclosable to enquirers, but not shown on the face of the on-line register. The item that we particularly had in mind was the doctor’s registered address. I should just say that, at the minute, the on-line search does not include the registered address of the doctor.

Level 3 was information which we would say was accessible but on a restricted basis. We had in mind there information like the photograph that we will hold from now on for new applicants for registration; the doctor’s date of birth, and perhaps the date that his annual fees fall due. We thought that information would be disclosable to employers and potential employers.

Fourthly, the final level would be information that could only ever be exchanged between us and the doctor. We hold information about a doctor’s bank details in order to collect annual fees, and we would not disclose that to anybody.

In implementing this new tiered approach, we plan to utilise the internet and to develop two separate products. The first product would be the list of registered medical practitioners, and it would satisfy our requirement to publish that list. It would be the thing that would be accessible to all enquirers.

The second product would be the thing that would allow us to restrict level-three information. That would be a protected part of the GMC’s website, accessible through various security codes – the information provide to employers or potential employers, potentially perhaps other regulators as well.

We have consulted on this approach. It was as part of our consultation on the licensing and revalidation regulations and the guidance. Over the coming months, the Registration Committee will take forward that work, and the responses that we receive to that consultation. It will also need to bring forward the various changes that would be needed to standing orders and to the regulations in order to have that happen. So that will be work for the Council to consider in the future.

Our aim is to have those new products and that new system in force by the end of the first quarter of next year. As you would have heard at the presentation on the SAP project, it is a little bit tied to the technology improvements that we need to help us deliver it.

That brings me to the recommendation at the end of paragraph 30, which is the first recommendation for you.

THE PRESIDENT: Essentially, this is work in progress at the present time.

PROFESSOR CHRIS BULSTRODE: I have two comments. First of all, paragraph 27c and level 3, could I make a suggestion that it should not just be employers and prospective employers but also examination boards? National examination boards could find that sort of information, to verify who the candidate was, extremely useful.

Another, more general point is that it would seem that this is a classic document that should go to a patient and public involvement group to look at. At the end of the day, they are one of the major customers of this document, and therefore this should be one in which they should be involved.
**THE PRESIDENT**: It is difficult, given the tenor of the debate we have just had, to deny that, I guess.

**DR EDWIN BORMAN**: Paragraph 27b – the doctor’s registered address. With respect and with apologies, the passage of time does not necessarily mean that a principle necessarily gets changed.

This was the subject of quite some debate about five years ago, in which it was pointed at – and at that stage accepted and honoured – that the doctor’s registered address, which in most doctors’ cases, for very good reasons, is their home address, would not be made accessible on internet searches.

**THE PRESIDENT**: That is what the paper says. My reading of it is that this is disclosable, but is not disclosed on the web. Have I got that wrong?

**DR EDWIN BORMAN**: Then I have misunderstood it. Perhaps Amanda could correct me on this. I am quite happy to be corrected. It will save you all the rhetoric as well!

**THE PRESIDENT**: Are you happy with that? Assuming that is correct, you are happy?

**DR EDWIN BORMAN**: I just wanted an assurance that the registered address would not be --

**THE PRESIDENT**: On the web. You have it.

**MR FINLAY SCOTT**: That is correct.

**DR NICOLA TOYNTON**: It is such a minor point that it is hardly worth making, but if I do not make it and it stays as it is, it will irritate me.

On Annex A there is the column which says “Gender”. As a medical organisation, I think gender ought to be “M” or “F” and not “M” or “W”. “Men” and “Women” refer to toilets, not to gender!

**MR FINLAY SCOTT**: Strictly speaking, it is “Sex” rather than “Gender”.

**THE PRESIDENT**: I am sure that we can accept that as a correction.
PROFESSOR WENDY SAVAGE:  This has to do with paragraph 27c, the information accessible to employers and prospective employers. In practice, will this be the senior person in the human resources department, or will it be the most junior temp who comes into the department? If this is not protected in some way, then it is almost like giving it to the public – and I do not know if that is our intention.

MR FINLAY SCOTT: The point is that it will be accessible, as Amanda was explaining, through password or PIN-protected type access facilities. We would only grant those to organisations on a basis that keeps them secure. If they are not kept secure – i.e. if the confidentiality is in effect breached – then the facility will be withdrawn.

THE PRESIDENT: Are you content with that Wendy?

PROFESSOR WENDY SAVAGE: Yes.

PROFESSOR JAMES DRIFE: I was not sure whether the point that Edwin was making was answered as far as paragraph 27b is concerned. If I couch it in terms of my daughter, who is an SHO in psychiatry, who has to make decisions about whether patients are likely to go out and behead other people in the country – is it feasible for one of her patients, if they do get out, simply to phone up the GMC, find out what her registered address is, and go round with a machete? I am interested, because her registered address is my house!

THE PRESIDENT: The answer is probably yes.

PROFESSOR JAMES DRIFE: Is that acceptable? As Edwin said, there was quite an animated discussion. Bearing in mind that very shortly half the medical profession is going to be female, should women doctors be put in the vulnerable position of having people able simply to ask what their home address is?

THE PRESIDENT: As the years pass, my memory completely fails on this. I thought that the debate related to access on the website. We have always had the register in public libraries or wherever else, where the registered address has been readily available to anybody. I suspect that we have a duty to make it available to anybody.

MR FINLAY SCOTT: As Amanda will confirm, what Graeme says is absolutely the case. There is a requirement for a doctor to maintain an effective address, and there is a requirement on us to make it available.

There is an existing policy decision, which is the one to which Edwin referred, not to make the registered address available on the web. We nevertheless are obliged to make it available on enquiry.

There is, however, a question mark around the utility of the registered address. There is
further work that is going to be done on that. However, the description that Graeme gave is absolutely correct: it reflects the statutory position at the moment.

**DR ROSALIND RANSON:** I read paragraph 27b in exactly the same way as Edwin read it. I know that we have your assurance that it does not mean that it will be on the web, but can I have an explanation of what it does mean when it says “not shown on the face…”?

To me, this says that it is not shown on the face of the on-line register but is disclosable to all enquiries, maybe on a different level; maybe they had to put some other search enquiry on. Can I have an explanation of what it means by “not shown on the face of the on-line register”?

**MS AMANDA WATSON:** What we meant to say there was telephone enquirers. So if someone enquires by telephone, they will be told the doctor’s registered address. It would not be on the on-line search, available to all enquirers; it would be in the employer-restricted information. But if somebody has the name of the doctor and they want the address, they phone up the GMC and they get the address.

I have to say that was our proposal. That is what we went out to consultation on, but there is some further work for the Registration Committee to do following the responses to consultation. There are concerns in some quarters about address, and there are different mechanisms for dealing with that. At the minute, we only have one address, but we could introduce the concept of a contact and a registered address, and so on. So I think that there is perhaps some more work to be done. This is our current proposal and we will be bringing back to the Council in due course whatever are the final conclusions from the consultation.

**THE PRESIDENT:** This currently reflects what we do. This is not a change in the current practice. Am I right in saying that?

**DR ROSALIND RANSON:** I understand the explanation is what we currently do, but what Amanda has just said is not what it says in level 2. If it said, “The information will not be available on on-line search, but will be available by telephone”, I would be happy with that.

I know that it is not our intention but, to me, level 2 does not read as to what the verbal explanation has been. So I would not like this to go as it is, and would like it to be changed to what we all understand by it.

**MR FINLAY SCOTT:** The purpose of the words is to capture the policy, and we will happily modify the description in the next version of this. For the avoidance of doubt, however, I repeat the point that Amanda has made.

In accordance with the established policy, the registered address will not be displayed on the on-line register but will be disclosable in response to enquiries, whether by telephone or any other means, except through an internet search. That is the established policy position.

Perhaps I may explain, because it may not be immediately obvious, why the policy takes this form. We are under a duty to disclose the address. What then, might the innocent bystander ask, is the problem with putting it on the web? After all, you are only making it available in one other form. The answer is, if you want the doctor’s address you have to start by knowing that you want the address for that doctor – as distinct from scanning down registered addresses to find doctors who happen to live within five miles of you so that you can go round
and knock on the door. That was one of the arguments that was advanced.

It is not about confidentiality. Given the statutory duty, it cannot be about confidentiality. However, there was an understandable unease that doctors would be identified, not as a result of a prior connection with someone, but through geographic proximity. That was essentially the argument.

PROFESSOR WENDY SAVAGE: We have a statutory duty, and I think that Finlay's explanation is helpful. It is important, in GMC News, to bring doctors' attention to the fact that we have this statutory duty, so that those working in psychiatry for example can use their work address as their registered address rather than their home address.

I looked somebody up yesterday and the address was the work address, because this doctor is a psychiatrist. Maybe we need to put it in GMC News more than once that this is our statutory duty, and if you do not want anyone to know your address, then use your work address.

THE PRESIDENT: Are we content?

DR PETER TERRY: Almost. I have a slightly different question. I am quite happy that this now represents our accurate register. I do want to ensure that is exactly what it is, namely doctors who come off the register will no longer be on this computer system.

The second part of my question is this. Assuming – and it is an assumption – that this links to the strategic application projects that we saw this morning, and which was extremely impressive, what do we do with that information once it comes out, as it were, in the public forum? Presumably we are still keeping information on doctors, for instance, who have been erased.

THE PRESIDENT: Presumably it is in line with the policy we agreed last November about disclosure on those elements. Amanda, do you want to answer?

MS AMANDA WATSON: At the time we went out to consultation on these proposals, we did conceive of the list of registered medical practitioners being the list of people who were currently registered. Within the last few months, however, even since the consultation exercise was undertaken, there have been increasing calls for more information to be disclosed. That is, not only about doctors who are currently registered but about doctors who may have been erased; the argument being that if a member of the public were to search the register or the on-line search facilities and find a name is missing, they might not necessarily draw the conclusion that there had been some fitness to practise history there of which they ought to be aware, and they may be about to commission services from somebody who could be advertising themselves as registered but in fact was and is no longer.

I think that would be work that the Registration Committee will need to take on board, in terms of the responses to consultation. Indeed, there has been Harry Caton’s work in terms of the expert group on cosmetic surgery, which is also something on which we will not be able to conclude our work, in terms of the registration aspects, without taking that on board. So I do not think I have a “yes” answer to Peter's question.
THE PRESIDENT: Do you want to pursue that further, Peter?

DR PETER TERRY: It seems to me that it is not a “yes” answer, or indeed a “no” answer. I fully appreciate the difficulty. However, if the register is the register, as it were, and a source of public information about individuals who can practise medicine in this country, I would like to have perhaps slightly more reassurance that that is exactly what it is.

MR FINLAY SCOTT: I think that this will have to come back to Council through the Registration Committee, because I think it is a very good example of what Harry Caton was pointing us to: that we have to understand the utility of our register to those for whom it has been designed, who are not necessarily all represented in this room.

I think that you can at least mount an argument that there are three logical concepts. One is names in a register; as a subset, those who are registered; and, as a subset, those who are licensed. I think that the question Peter is asking is that we certainly have to display those who are registered, and consequently those who are licensed, but do you start by displaying them as a subset of the names you have in your register? That is a question that Council needs to come back to, because there is undoubtedly an argument that it could be helpful to members of the public, and indeed to others.

I am not saying this is a decisive argument, but when Dame Janet challenged our policy in relation to the handling of complaints against people who turned out not to be registered – and our classic response is, “It’s nothing to do with us” – what she gently chided us with was, “Perhaps they are practising as though they were registered, and doesn’t the GMC have at least an incidental responsibility, if it comes into possession of information, to do something about that”. So I think that it is quite complex and it needs to be considered on the basis of a paper.

DR PETER TERRY: I am happy that this is not absolutely decided today and that we will consider it again. Indeed, I think that is exactly what we need to do. It clearly is far more complex a question than even I thought it might be at the start.

The second part of my question was in relation to the strategic application project. I assume – and I have no problem with it – that information that we gather will, subject to the legal requirements, still be kept for possible future purposes but not form part of the official register.

THE PRESIDENT: I presume the answer to that is yes.

MR FINLAY SCOTT: Like many organisation, I think that we are wrestling with the tension between the data protection principle on the one hand – which essentially says, “You will not hold personal data for longer than you have a reason” – and the kind of issue that emerged in the Soham murder cases.

I am very happy to talk to members after the meeting about how Amanda is responding to resolving that kind of tension, but I would rather not discuss it at the moment – if that is all right.
THE PRESIDENT: I am frightened to pursue this, given your hint. However, given the discussion yesterday where we envisaged that our register might be used by others, with the data put on to it, why would the same principle not apply to ourselves? We have a register, but we use it for our own purposes, for additionality.

MR FINLAY SCOTT: There is a whole range of issues that we need to ensure that we cover for. One of the obvious points, which was associated with the discussion around the database, is the point at which you become responsible as a data-holder for what it is you are holding. So there is a whole range of things, and Amanda has recently increased the capacity of her directorate to deal with some of the complexity.

THE PRESIDENT: Coming back to the matter in hand, rather than going further down that byway, which is very interesting, are we content with the direction of travel and the recommendation which is up to paragraph 30?

DR ALEX FREEMAN: I have a couple of questions. At the moment our on-line search facility does not reflect the whole of the medical register. There is a disclaimer on there that it does not, and people then have to telephone the GMC to make further enquiries.

It might be helpful to people who are searching the on-line facility to say under what sort of circumstances somebody may not be found on there – because it does not necessarily mean that there is a problem with the doctor. It may be that, for example, they have been referred into fitness to practise; there has been nothing proven, but there are ongoing enquiries. It would be quite helpful to expand that disclaimer, and to give information saying that if you do not find someone in an on-line search facility it does not necessarily mean that there is a problem there.

The other matter is around the issue of the doctor’s registered address. You can have a doctor who is practising in one part of the country whose registered address is at the opposite end of the country. How can a member of the public, who is trying to identify a doctor who is practising in their area, reconcile that with a doctor whose registered address is at the opposite end of the country?

We are obliged to have registered addresses for doctors for our own purposes, but we need to start say to ourselves, “Yes, we are supposed to have a duty to disclose this” and so on, but how much use is it? This might be something that we should take back to the PPRG. Under what circumstances is it necessary for a member of the public to know their doctor’s registered address, and why would it be useful to them?

I think that we are going to have increasing problems with people trying to protect their privacy. Certainly there have been documented cases of doctors being stalked, because somebody has found out their registered address from the GMC. I think that we have a moral duty to look into that and to justify why we do what we do. I do not think it is good enough to say, “We disclose it because we have to”. We need to be able to justify why we disclose it. If we decide that we cannot find any justification for disclosing it, maybe we ought to look in the direction of changing the law.

THE PRESIDENT: I wonder if that was incorporated in Amanda’s opening statement, saying that this would come back to the Registration Committee, for them to look at a registered and a contact address – which I think was the phrase used. I think that there is an issue to be explored further here.
**MS AMANDA WATSON:** The address is used for two reasons. One is around identification and, for the reasons Alex has explained, it is probably not a particularly useful tool for identification. We would probably rather that people knew the doctor’s GMC reference number, because that is a unique identifier and a much more accurate way of figuring out whether we have the correct doctor or are talking about the correct doctor.

I think that the Registration Committee’s decision in principle about a registered address was related to the fact that if somebody wishes to make a complaint about a doctor, we need to know where to contact them. It is very difficult to reconcile that with a desire to keep an address out of the public domain.

I can tell you that we get 7,000 enquiries every day on the on-line search, and 70 per cent of those are done without the GMC reference number. Most people are therefore using some combination of name and postal town in order to identify somebody. It may be that, as Alex has indicated, the work we need to do in terms of involvement with patients is partly about education around what is the best way of making information available and helping people to access the register.

**THE PRESIDENT:** Did I understand that you will shortly have a paper to Registration and therefore back to us, looking at some of these issues? So the issues that Peter and Alex have raised will come back to us in any event. Have I got that right?

**DR ROSALIND RANSON:** Following on what Amanda has said, I hope that doctors will be included in the consultation because it makes sense that perhaps that is what we ought to be making known to our patients, namely our GMC number.

There are a lot of doctors who do not even use the name they have registered with as the name that they are practising under. The patient might know them as Dr X when they are actually registered as Dr Y. If the doctor has to display their registration number, then that would not be a problem. Maybe we ought to be looking at that as a way that medical practice ought to change, in that we ought to be routinely making our registration numbers available. I would not have thought that doctors would have a problem with that, and it may help patients.

On level 1, it says the postal town of the registered address would be immediately available. It may be that a locum lives in London and his registered postal address will be a London address, but he may be working in Scotland.

**THE PRESIDENT:** Or even in some cases vice versa!

**DR ROSALIND RANSON:** So maybe that ought to be included in the consultation.

**THE PRESIDENT:** I am hesitant to see if we have agreement on this. I seem to have got it wrong the last three or four times. However, with those comments, are we content with recommendation 2a – that is up to paragraph 30? [Agreed]

Amanda, do you want to take us through the last remaining eight paragraphs?
The changes that we have just been discussing will take some time to deliver. We expect to have those new products available by the end of the first quarter of 2006. In the meantime, we need to consider what changes should be made to our existing on-line search.

At the current time, you can search via the GMC's website. It is called the on-line search, and somebody made the point earlier that it is not actually the medical register. It is a search of registered doctors. Where there is no fitness to practise action taken or being contemplated, you will – provided the doctor is registered – receive information which confirms the name, registration number, postal town, and certain information about the registration status – what sort of registration they hold.

Since July 2003, you can also access information about fitness to practise decisions. You get that information by entering the reference number or the name combination, but it is in a different part of the GMC’s website. It requires you to have some knowledge about that. If you did not know that information is published in two places, it would not, on the face of it, occur to you that you needed to look in these two different places.

In addition, if people want to make an enquiry about a doctor and they phone up our helpline, they are not automatically given information about conditions or undertakings. What happens is that the caller is put on hold and redirected to a case worker in the fitness to practise directorate. We heard from Dame Janet Smith about an example where she had tried to do exactly that, to find out the information, and her perception of the service she received was that it was terribly slow. She was left with the impression we were trying to withhold information. In fact, our ambition is to try to make sure that the information is given accurately, and of course to the right people, because we want to make sure that we are giving information to employers or potential employers.

What we are proposing to do is to introduce a revised protocol, to make sure that we do release information promptly where it is appropriate to do so. We will have a protocol between the people who man our helpline services and the fitness to practise directorate around what information is given and in what circumstances, so as to improve the quality of the service for people who telephone the GMC – because at the minute they probably are left on hold for some time, while somebody attempts to track down the relevant person, to read out to them the information which is contained on the computer system.

In addition, we propose to expand the services provided on the existing on-line search facility, so that it will include information about practice conditions and practice undertakings and suspensions. That will not go all the way to delivering what we want in the longer term, but it will fill a gap where there is a demand for better information, more readily accessible. We plan to introduce that by the end of June this year.

That brings me to the second of the recommendations at the end of paragraph 38.

So it is making our facilities a little more accessible, a little more reasonable. You heard Harry Caton this afternoon also saying that the website requires some kind of amendment.

This is not a comment directly about this recommendation. I am just rather concerned about the assertion that the doctors are practising under names they are not registered as. As the holders of the register, should we not be insisting that they register the name they practise under? It seems to be misleading. I know plenty of people who are married and will be Mrs Something and Dr Something Else, but they are registered as Dr Something. To be practising under a name which they are not registered as, is the
opposite of transparency and we should not encourage it.

THE PRESIDENT: I am not sure we have the power to do that, have we?

MR FINLAY SCOTT: If I may say so, Nicky asks a very good question. There are perhaps two categories. There is the category – and increasingly I am not sure that it only affects women – where people continue to practise under a maiden name, despite the fact they are now married and may have changed their registered name to their married name. Maybe because there is no mal-intent in that, we can find means of dealing with it, not least because we would hold both names.

What is slightly more worrying is that, within fitness to practise or registration – I cannot remember where – we currently have a case where it is being alleged that a doctor, on the face of it, deliberately is practising under five variations on his name. I think that, at that point, you have to ask why.

In the case of legitimate changes of name, I think we can deal with that. What we perhaps do need to make clearer – which may flow from the individual case we are considering – is whether the stricture should be that the whole point is to create the link which Nicky has identified, between how you present yourself to patients and how the information that is held in the register.

DR NICKY TOYNTON: I still do not understand why you would register in a different name than you were using, if it is a medical register you are registering with. That seems to be unnecessarily confusing.

If you have been called Dr Something every day and in your paperwork, why would you want the GMC to write to you as Mrs Something Else? That just seems a nonsense. As we hold the register, can we not say, “You have to register in the name you practise in”?

MR FINLAY SCOTT: It is a very good question. I hesitate to say anything about the desires of the soon-to-be 60 per cent of doctors who will be women. I think that we have to be reasonable as an organisation, with a reasonable degree of flexibility in relation to what one would regard as a legitimate use of name. I think that it is the illegitimate use of a name that would worry me.

MR STEPHEN BREARLEY: May I suggest that this is really a no-go area? It is not because of women who may change their name when they get married. It is because of names from different ethnicities, some of which are multiple, any one of which may be regarded as the family name, the patronymic, the first name, the given name, the favoured name, or whatever. We get terribly confused in Registration about which name comes first and which name comes last, and by which name we should refer to doctors by. Quite frequently, from report to report, they seem to use different ones. It is totally uncontrollable, and we can do nothing about it.

DR NICKY TOYNTON: But if you practise in one name, can you not register in that name?
THE PRESIDENT: The issue is whether we can force the issue, I think. It may be dependent on why people are doing it. If it is a totally benign arrangement, that is one thing. If it is done with mal-intent, it may be another.

DR EDWIN BORMAN: Stephen has drawn attention to the most likely reason why the name that a doctor uses in their practice may well be different from the name under which they are registered. I would ask that members here consider that the reasons for that are frequently because doctors are shoehorned into our bureaucratic needs, rather than a recognition of their background and a recognition of the way in which the society in which they have grown up, or the society in which they have functioned, would address them.

So could I please ask people to be more mindful of the wider cultural implications of a discussion of this nature? What I would say – and perhaps it comes back to the point that Rosalind raised earlier – is that this may provide greater impetus, given that there is an awareness of this issue, for doctors to be identifiable by a clear statement, namely a number. The GMC registration number truly is the only single identifier that is applicable across all contexts.

PROFESSOR JAMES DRIFE: We may all have been saying the same thing but, having read out the Sri Lankan names at the college ceremony, I think that a doctor having to introduce himself or herself to every single patient with a multi-syllabic name is not realistic. As Edwin has said, we must not make ourselves ridiculous by failing to understand the perfectly benign reasons for a doctor wanting to make his identification easier to patients.

THE PRESIDENT: It is not directly linked to the paper in front of us, let me remind us all.

PROFESSOR IAN HUGHES: It is the same point. Long, polysyllabic names for patients with mental illness is something I have come across, and I also know a number of doctors who have chosen to introduce themselves routinely to their patients with a very short name as an abbreviation.

THE PRESIDENT: We are back on track to the paper in front of us and the recommendation 2b at the end of paragraph 38. Given the tenor of the debate so far, I think that we are content. [Agreed]

4c. Developing a risk-based approach to regulation: the early identification of impairment

MR PAUL BUCKLEY: There is a surprising amount that we perhaps do not know about fitness to practise and poor performance. Not least, we do not have wholly reliable data on what proportion of doctors may be impaired in terms of their fitness to practise. The CMO for England has said that the figure is perhaps five or six per cent, but what is more generally agreed is that that is a small proportion. Most doctors are fit to practise, and revalidation will enable that to be affirmed in a way that will command public confidence.

However, that five per cent or so can cause significant harm, especially where the problems deteriorate to such an extent that the GMC needs to be involved. In the past, the GMC, for
want of a better mechanism, relied mainly on complaints as a way of identifying these doctors. The limitations of that approach became increasingly apparent, including that complaints do not necessarily direct you to all the doctors who need to be closely looked at. Even in respect of those doctors who are complained about, by the time you have the complaint the damage may have been caused.

Ideally, therefore, we should be trying to find other ways of identifying at the earliest possible stage doctors who are impaired or, better still, who are not yet impaired but who are on a downward path. In order to do so, we need information about the nature of impairment, including about the circumstances in which it is most likely to arise. In other words, we need a risk-based approach.

Of course, this is not a new concept to the GMC by any means and it is not the GMC alone that is wrestling with it. Most regulators are moving away from a one-size-fits-all model to a more sophisticated approach which recognises that a lighter touch is necessary for some, and more detailed scrutiny for others.

The benefits are obvious. They include better use of resources and time – both regulators’ time and that of those who are regulated – and, crucially, being able to anticipate problems before they arise. The paper argues that this is increasingly what we should be doing and it goes on to suggest some ways in which we might do so. Perhaps I should pause there and take the first recommendation, which is about the overall approach that we are wanting to move towards.

**DR RACHEL ANGUS:** This again continues the theme of the NHS and employers being the first contact with doctors who are beginning to go wrong, or who are at risk of going wrong – which, although not outside our sphere of interest or even our sphere of interest perhaps, is not our brief.

The big issue is that people close to that doctor often know that that doctor is going off the rails, and it is how the colleagues and the people close are able to blow the whistle – and I do not really like that term – to report or to advise the employing authority of what is going on. At the moment, I believe that is a very problematic area in trusts that I have connections with, and it is perhaps something else that the CMO could consider.

**THE PRESIDENT:** Thank you very much, Rachel. It is already part of the remit there, I think.

**MS RUTH EVANS:** It is a very small point but, as it reads, the GMC is to adopt a risk-based approach and it sounds rather perilous. I would say that it was a risk mitigation programme.

**DR EDWIN BORMAN:** I know that this is the second time I have seen this concept brought to members of Council. Previously it was in the work-up phase, and I have to say that I am still concerned that we are exploring this area – for the following reasons.

Like Finlay, I believe in a tiered approach to regulation. I have to say that I do not believe that this component of the tier belongs to us. I suspect that there may be other people round the table who will disagree with me. However, picking up on paragraph 17 and the issue of proportionality, I believe that there does come an argument where we have to look at ourselves as the central national regulator and say what is our role with regard to regulation of this profession, what is our responsibility, and what is the role and responsibility of others.

To my mind, there is a clear-cut argument to be made for the regulation of those doctors
where there is a significant enough complaint that may have an impact on that doctor’s registration – as it has been to date, in the previous view of this concept and indeed in this paper, which I have to say is relatively short of a concrete indication as to what is being referred to. I am not persuaded that we should, to a greater extent, be looking into what I believe are the responsibilities of other tiers of the regulatory “onion” – if we are calling it that, since it is a collection of layers.

There are other reasons for this. The NHS, which remains the dominant employer of doctors in this country, has regrettably been rather absent in exploring this issue. Indeed, it has been even more absent in addressing problems when doctors have had difficulty. The NCAA has been a notable exception, and I have to say an impressive exception, to that previous history; but I found rather disturbing the way in which the NCAA now is being superseded – and perhaps Bob would like to speak a little more about that, hopefully a bit more openly.

THE PRESIDENT: But not just now, I think.

DR EDWIN BORMAN: I would ask members around the table this. While it looks attractive, could you think a little more broadly in terms of “Is this really what we are about?” and how much of this sort of thing is the responsibility of the employer, of colleges, of peers at local level, and indeed for them to resolve at that level? Are they not better placed to deal with it at that level, given that the potential degrees of dysfunction, or the potential warnings of dysfunction that have been spoken about, should also be addressed at that level, and are not part of what we are about?

PROFESSOR CHRIS BULSTRODE: Could I take exactly the contrary view? I would strongly endorse this recommendation. We have been doing some pilot work on this, on looking for at-risk factors in terms of professional behaviour in medical students. It is tricky; it is very interesting work; but it is highly rewarding.

I quite understand Edwin’s concern but, at the local level, a trust may find they do not have the resource, the expertise, or the will to try to develop these kinds of tools. At the college level we are finding exactly the same problem. I think that it is something the GMC should be taking a lead on in collaboration with these other organisations, because there is a huge amount of work to be done in identifying these factors, validating them, and getting the culture to change. That is one of the things we have to do with medical students – to get them to accept that this was a good way to go forward. Alan said this morning that this might take a generation. I hope that it will not take that long. The GMC has to be behind this, pushing solidly and steadily, if it is going to be brought about.

THE PRESIDENT: The discussion we had previously looked at this as the obverse of the criteria and standards and evidence for good practice. We need to keep that in mind.

MRS ANN ROBINSON: I am also a supporter of this paper. I think that it is a very good piece of work. However, like Ruth, I have problems with calling this a “risk-based approach”.

If we turn that round and think about the discussion we had this morning – and, again, building on Finlay’s concept of the tiers – what we are talking about is how to provide tools and the framework to make the whole of the regulatory framework, recognising that there are different roles for different people in this. We obviously have a clear role in setting standards, but local services also have a role. If we think about it more in terms of giving people
guidance tools to make that work effectively, it may be a better way to describe it.

We got to that point this morning – aided by Fiona’s comment about having some sort of memorandum of understanding, or more guidance, or whatever – and Gillian quite rightly took us to the issue of performance management and so on. People need standards and tools to help them to do that, and I think that this is a good approach. It may not be exactly right, but nevertheless I think that it is the right approach – because we have to have something more than fine words.

If we are expecting employers to do a job, then I think that we ought to be in a position where we give employers some help and some tools to enable them to carry out that job. That is why I am behind this approach.

DR MALCOLM LEWIS: I am joining the list of people who are opposing Edwin on this! It is an excellent paper, and I think that it is a shame that we are in this habit of dismantling papers and taking individual items at a time – because the whole thing with this is very much what Ann has just been talking about, and what we were talking about this morning. It is about ensuring that the GMC-approved, managed, systems – whatever we call them in the end – fit in with what we need in terms of clinical governance and appraisal, if those are still to be the routes that we are talking about towards revalidation.

This is an essential piece of that equation and it is right that the GMC, in setting standards, should be able to work on issues such as “research into indicators of future serious impairment” – item 2c – and to work with the NHS and regional providers, in order to come up with the parameters they can look at within clinical governance systems. We can then quality-assure those systems, to be confident that they are delivering what we need in terms of the individuals working there, and their revalidation – as a whole package.

I think it is an excellent paper and it gives us that piece of the jigsaw that we are looking for.

PROFESSOR ROBERT SHAW: I would support Edwin, in that it is highly important that the GMC should be able to recognise issues that could affect a doctor’s performance; to recognise, perhaps through the revalidation processes, pointers that may indicate underlying trends. However, we do not have any means of then acting upon those issues where it does not highlight an issue where registration is actually at risk.

We have an organisation called the NCAA which has been set up to recognise, help identify and provide plans of retraining, to ensure that these issues are addressed. I think that our problem is that we do not have any means of following through afterwards, having recognised them – when fitness to practise is not so severely compromised that registration has to be restricted.

So we need to know about them; we need to contribute to the process and highlight these issues through educational training programmes to undergraduates – but I think that it really is the responsibility of others.

THE PRESIDENT: If I get your drift right, you are quite happy that we are responsible for setting those standards. It is the implementation thereafter which you think should fall to others. I suspect that is common purpose round the table. It is not the pursuing of these issues that we are talking about just now: it is setting standards and our role in setting up those flags. However, others may disagree.
MR BOB NICHOLLS: I think that we are nearly there. It has been polarised, with Edwin and now Robert Shaw versus the rest. I do not think that it feels like that at all. It feels to me that Ann and Malcolm are getting the right balance. This is not for us to be doing; it is for us to be setting the standards.

I am conscious that, from the public perception – and there have been a lot of pilot analogies today – we all want to be flown in planes which other pilots would go in. We all want to have doctors that you doctors would go to. I think that the early signs, the risk-based approach, the identification of early problems – on which, yes, the NCAA has done some useful work, but it is only just beginning – is critical to that.

It was put to me somewhere that we need to raise the level. “You will get struck off if you are this bad” is not good enough for the public. We need to be encouraging other people, and I think that responsibility for spotting is mainly with the other people. There are the still unmanaged doctors, where we could perhaps be doing some piloting and we could be spotting some of these. If we were looking for the risk-based approach in unmanaged areas, I think we might get some quite nasty early indicators.

We should take the paper as a whole, and the need to work with other groups. However, we have a responsibility as the Council to be saying that this is a very important area, in which our end-of-the-road role – which is what the fitness to practise is – is not enough to reassure the public that they are getting the doctors other doctors would go to.

THE PRESIDENT: It may be helpful to see our role as setting the standards, with somebody else to be doing the “doing” of it. I do understand the distinction there.

DR KRISHNA KORLIPARA: Let me try to tease out what we do and what we are planning to do. At the moment, if either the local mechanisms fail or the public is seen to be at risk, the cases are automatically referred to the fitness to practise panels, after the due processes.

You cannot really argue with what we are suggesting in paragraphs 21 to 23; but when it comes to the recommendation that we should adopt an approach to regulation which is increasingly risk-based, I suspect that we need to be much more explicit in saying that, when either the local mechanisms fail or the public are at risk, the GMC will step in. Otherwise, we are effectively saying that we are going to take all and sundry who have any indicators of performance dysfunction. That is not our function. I think that we ought to work in collaboration with the other agencies which exist.

THE PRESIDENT: I very much agree with that. As Malcolm said, it is the fact that we are taking this piecemeal. Nevertheless, that is the way it is with us at the present time.

PROFESSOR WENDY SAVAGE: I think that this is far too important a paper to be having at this stage in our proceedings. There are some extremely interesting ideas, and that we should get involved in setting the standards.

My problem with this is that I do not like developing a risk-based approach to regulation. What we should be saying is “exploring the criteria and standards to assist the NHS”, or something like that. I cannot do this on the hoof. I would say that this requires a lot more discussion in the future, and that it would be wrong to try and rush through agreeing these recommendations.

There are a lot of complicated ideas in here and if we said that we were going to explore this
further, then I would be perfectly happy and I would vote for it.

**THE PRESIDENT**: The recommendation is an approach, so that is what it says. However, Finlay has suggested that we might try to amend things with a common stem.

**MR FINLAY SCOTT**: I think that Malcolm is right. There is a sense in which we are losing the sense of the paper as a whole. I missed Ruth’s suggested amendment to the first recommendation, so I will take it as it stands ---

**MS RUTH EVANS**: A risk-mitigation approach.

**MR FINLAY SCOTT**: Risk-mitigation approach – with that word inserted, I personally think that it is pretty difficult to resist the first recommendation. You have finite resources. You do not want to impose an undue regulatory burden. You have to think about where to apply your resource – so you adopt a risk-mitigation approach. It is fairly straightforward, and I would be really surprised if the Council could not sign up to that as a principle without much difficulty.

I think that the problem which has been caused in relation to the second and third recommendations is that there is a confusion in our minds – and the same is true of the fourth, so it is (b), (c) and (d). What the paper is essentially saying is that, in order to assist other people who do not have the sort of breadth of view that we have, we would like to do work in these three areas. So what each of those recommendations requires is a preamble – which I would prefer not to have to draft with great precision on the hoof, but it runs along the lines of, “to assist employers and contracting authorities and to support local systems, …”. That then draws the distinction between the work that we do to develop the indicators, and those who will actually apply the indicators in practice. I think that would deal with some of the disquiet that is being expressed.

Given the cautious nature of the language, I do hope that the Council – notwithstanding Wendy’s suggestion – will be pretty positive about this, because I think that this is an important contribution that we can signal to Liam Donaldson’s call for ideas.

**THE PRESIDENT**: Perhaps I may make a suggestion. Would it be sensible if we had a break for five minutes to have a cup of tea, during which time perhaps Finlay could string a few words together that might allow us to come to a fairly quick conclusion on this one? Would that be an acceptable way forward to you? [Several members: Yes]

[A short break]

**MR FINLAY SCOTT**: Can I do this in two parts? First of all, I am assuming that recommendation 2a has been agreed.

**DR JOAN TROWELL**: That is not using “risk-based”?
MR FINLAY SCOTT: “Risk-mitigated”. Before I hand over to Paul Buckley, I want to explain that the form of words we have produced is intended to do two things. First, it is intended to meet the legitimate concerns expressed by Edwin, who was kind enough to discuss with me while you were all having your tea. Secondly, there was a very helpful suggestion from Alan Craft that we should make it clear that we were going to do this in conjunction with others. That is also a response to Edwin’s concerns – so that we see this as a shared venture.

MR PAUL BUCKLEY: The form of words we have produced is a stem that would go in front of 2b, 2c and 2d. It reads – not terribly snappily – “In order to support the local identification of actual and emerging impairment and in conjunction with medical royal colleges, postgraduate deans, employers, the NCAA, patient and public groups and others, (b) to agree…; (c) to agree…; (d) to agree…”. I said that it was not snappy!

THE PRESIDENT: Could anybody suggest an organisation we have not included!

Wendy suggests that we should be using the new abbreviation for the NCAA, and I think that we probably should be.

MR FINLAY SCOTT: “…(soon to be the NCAS)” – yes!

THE PRESIDENT: Are we content with that? [Agreed] Are we therefore content with the concepts being (b), (c) and (d) as written here? [Agreed]
Developing Medical Regulation
4a. Development of a European strategy and action plan

THE PRESIDENT: As I think that all the members know, there are a wide variety of issues here, relating to many of the different directorates within the organisation. This is a first attempt to try to pull that together and to develop a specific strategy and action plan. Claire Herbert will take us through the main points here.

MS CLAIRE HERBERT: The purpose of this paper is to introduce to you a proposed programme of European and international work for the GMC, in the form of a strategy that brings together existing work in which we are already engaged and also takes the opportunity to look ahead at some emerging developments that may be of interest to us to recognise and also to respond to.

The paper has already been to several policy committees, so I do apologise to those of you who have heard me introduce it before. Within the paper I have highlighted a number of areas that set the context for our European work. On the whole, these are the European regulatory environment in which we reside and our engagement with other medical regulators on a multilateral and a bilateral basis within this context; the European Union policy and legislative environment within which we sit, and the way in which EU decision-making and lawmaking have an impact upon the way in which we can fulfil our functions.

I have gone on to recognise the extensive European and international work in which we have already been engaged, and also to look ahead at emerging developments which may start to give a slightly different shape and focus to our activity, particularly the further enlargement of the European Union and, more generally, the general policy direction the EU is beginning to take – particularly with regard to finalising the Internal Market.

On a more practical level, you will notice in the annex to the paper that I have pulled together an action plan which details the much more practical projects and activities with which we might engage. This is very much a pulling-together of existing work that is already going on across the whole organisation and, as I have said, picking up some new elements of work in which we might engage for the remaining part of the year.

You will notice that it is in four parts. In brief, these relate to our ability to undertake proactive information and intelligence-gathering on European issues; our ability to influence the European regulatory environment and, hopefully, to shape it in a way that is positive towards our functions. It also focuses on the way in which we work in partnership – whether that be with other regulatory bodies in the UK or other regulators across the EU and the wider EEA. Finally, it focuses on the way in which we can raise awareness, both within the GMC and also outside, about the extent of our European and international activities.

In conclusion, the recommendation asks you to endorse the European strategy. Clearly, if you have any further suggestions about the way in which the action plan and the wider strategy can effectively reflect all the directorates and the organisation corporately, I would be very grateful to hear them.
THE PRESIDENT: Thank you very much indeed, Claire. That is very clear. I realise that this paper has been round most of the policy committees before it came to Council. Nevertheless, there may be issues that people wish to raise.

MRS ANN ROBINSON: I think that Claire has done a first-class job on this. It is an excellent piece of work and I think that she had got the focus dead right.

My comment is on the action plan, strategic objective 1 – intelligence activity, early warning, et cetera. I do not think that it can be emphasised enough that catching people when they have a gleam in their eye is essential. By the time the words are written on paper and a consultative document comes out, you have had it – it is too late. It is very important to be there, listening and aware.

My point in relation to that is this. I know that it is very difficult to do – I have tried this in the past with what was the DTI – but I think that it is worthwhile to try to get the Department of Health involved in all of this, so that there is a group there and that it is shared; that we are all sharing intelligence. They have absolutely to be part of that, however, in order hopefully to achieve a UK “hymn sheet” and a position – before anything else happens. However, it is often the politicians who will get wind of something at a pretty early stage. It does not just come from the Commission; it comes from other places as well.

PROFESSOR CHRIS BULSTRODE: Can I support what Ann has said? I found this paper absolutely fascinating. It is beautifully written, and I was very grateful for the introduction because one or two things were explained to me about the European Community which I had not even started to grasp.

I absolutely agree with Ann about the Commission. The sooner we get in there quickly, with clear, well worked-through suggestions – and I thought that this paper was a terrific start to that – the better it will be for us in terms of the Commission. I am sure they are looking for this sort of work to guide them, but it must be done at an early stage.

DR EDWIN BORMAN: May I assure my two colleague members, and indeed other members, that following discussions I have had with Claire, Richard and other members of the team, I have been really pleased – and I speak mainly in my capacity of doing international work for other organisations – with the approach that the GMC is now taking.

It concerned me quite a lot initially when I came here that the GMC did not devote sufficient attention to international matters. I am very much reassured. Further, I think that the GMC is developing a very active lobbying presence in Brussels, which I think is essential.

On the points that both Ann and Chris have raised, I note that the GMC is now actively speaking to the Department of Health. That is crucial not only in the early phases, but it is also absolutely essential in the very late phases. In terms of the co-decision processes between the Commission and the Parliament, and the final decisions being made at the Council of Ministers, it is absolutely essential that we are, as a regulatory body, able to influence our ministers when they ultimately go to make the decision at the Council of Ministers. I am therefore very much reassured by what I see in this paper, what I have heard in discussion, and also by the fact that we have a health minister, hopefully retaining his position, with whom we have very close contact on regulatory matters.

I would make one plea. I know that this is being taken on board, but I would ask for it to be taken on board still further. It is mentioned in Claire’s paper – and I would add to the comments made by Chris and Ann, that this is an excellently written paper, covering all the necessary areas. Brussels is the focus of an enormous amount of lobbying, and it is usually
very helpful to have joint lobbying going on – going to commissioners and going to the Commission secretariat, saying, “Look, it is not just us talking. It is us, plus all of these other organisations who represent an entire sector, who are all saying the same thing”.

It is better to get our act together before we go out and do the lobbying, rather than lobbying and finding that we are competing, sometimes on very small components of the message. I very much hope that we can see the GMC taking a lead in that particular area.

THE PRESIDENT: I think that everybody round the table would agree with that. It is important, not just at a European level but also within a UK context, to make sure that the Department of Health’s view coincides with ours and actually carries the day. Sometimes there is a bit of a split between the Department of Health and other government departments on these issues.

Are there any other comments on this paper? We are asked to endorse it. Do we? [Agreed]
GENERAL MEDICAL COUNCIL

COUNCIL

Tuesday 20 September 2005

4a. Annual Tracking Survey Pilot

THE PRESIDENT: This is an important issue for us, which we discussed more than a year ago. We agreed to set this up and we now have the first set of results to hand. Some of these too make slightly uncomfortable reading.

MS SOPHIA BHATTI: The paper before you today summarises some of the key findings arising from the annual tracking survey pilot, and copies of the full reports with their annexes.

Looking at some of the key findings that arise from the annual tracking survey pilot which was undertaken this year, initially the results from the public regarding awareness of the GMC appear to be disappointing – at 24 per cent awareness of the GMC’s goal of regulating doctors. However, we feel that at a national level those results are quite promising. In the light of the 24 per cent awareness, it is probably worth bearing that in mind when reviewing the results as a whole.

Promisingly, even with 24 per cent awareness, general confidence in the GMC and the regulation provided by the GMC within the public is quite high. I think that is an indication of much of the work we have been undertaking in recent years.

Overall, when we look at the policy approach of the Council, when we look at both the results from the public and the profession, the results indicate very strong support for the key initiatives which we have identified and have been discussing in recent years. I think that is also fairly promising.

The results relating to the profession’s opinions regarding the GMC’s link to local systems and revalidation pose some interesting questions, which we believe require some further exploration – certainly around revalidation. We understand that a piece of research is currently being undertaken by the licensing and revalidation team to explore some of the levels of understanding and awareness of revalidation and what that model currently means. This is to provide us with a greater explanation as to why there appears to be a lack of confidence, or why at least a third of those interviewed in the profession are not able to say, either way, whether they are confident or not.

Looking broadly at fitness to practise and complaints, there appears to be a very high awareness with regard to raising and pursuing concerns about someone’s fitness to practise or, if you are a patient, concerns about the treatment or care that you have received from your doctor. A number of issues have been identified which we feel ought to be addressed in the longer term, such as the barriers to pursuing a complaint by individuals that have been identified. Notably, the results indicated a perception of great bureaucracy and not knowing in which way to pursue a complaint. It is worth noting that there are a number of strands of work currently underway which are looking specifically at those issues.

Looking at confidence and trust within the doctor-patient relationship, not surprisingly, as many results of previous surveys have indicated, there is a high level of trust by patients in their doctors – 85 per cent. This has a direct correlation, as we have seen in the results, with the doctor’s communication and interpersonal skills.

Looking quickly at consent, again there appears to be a high level of satisfaction amongst patients and members of the public regarding the level of information they receive about their
care and treatment from their doctor – again communication is highlighted as being key to that.

Results relating to confidentiality indicate very similar thresholds on the part of both the public and the profession regarding the necessity to share information – primarily a correlation between being able and happy to share medical history for the purposes of medical research, teaching, et cetera.

Finally, looking at revalidation, the results indicate that, certainly within the profession, 52 per cent of GPs and 48 per cent of hospital doctors were happy that information obtained at local level could be used as the basis for revalidation. However, it is worth noting that the remainder do not disagree. A large proportion of the remainder were unable to provide an opinion either way. As I mentioned earlier, there is a piece of work currently underway to explore that further.

Perhaps I may stop there, at recommendation (a) which is to note the findings.

THE PRESIDENT: Yes. I was going to confuse the issue slightly, so you may have to catch this bouncing ball as it comes your way. The first recommendation is simply to note, and I do think that we should have a discussion about this paper. I am not in any way trying to pre-empt that. But I did wonder if we could look at the second recommendation here first, in a slightly paradoxical way.

Recognising that this is now October 2005, I wonder if the recommendation – instead of reading as it currently does, which is “To confirm that we should undertake a tracking survey annually” – might be amended to say something along the lines of “To confirm that we should undertake a tracking survey in 2006 and then consider whether it should be undertaken annual thereafter”. The fact of the matter is that 2005 is virtually gone; so the reality is that we will be undertaking it, in a sense, every second year. It is 2004 into 2005, and if we agreed to undertake it in 2006 – to review the findings at that point and make a decision about the frequency at which it should be undertaken – that might be an easier way forward for us.

Does that seem sensible to people first of all? [Several members: Yes]

I will read out the words again when we come to agree the recommendation, but that might help set the scene for some of the discussion on the first part. Are you happy with that, Sophia?

MS SOPHIA BHATTI: Yes, that is absolutely fine.

THE PRESIDENT: Comments then on the substance of the report?

PROFESSOR CHRIS BULSTRODE: I found the report very interesting. May I make one possible suggestion? Is there any way we could gather comparable data from any other country, like Canada or Australia? Is anyone else doing similar work?

I quite understand Dr Borman’s comment about trends, but we could also cross-compare with other organisations and see how they are doing.

THE PRESIDENT: It just so happens that I was at a meeting in Ottawa last weekend, and indeed there are similar pieces of information being gathered, not just from the Canadian side
but also from other countries. They bear tangentially on the data we have here, but
nevertheless they are informative. In particular, on the information that is made available to
the public on websites and so on – that too is available. So, yes, I can pass across the data
and we could see what might be circulated.

MRS FIONA PEEL: This is something which came out from some of the informal debates we
have had and some of the work that Sophia is doing elsewhere. We have been engaging the
public so often on the basis of, “What do you complain about?”. I think that this tracking
survey is beginning to move some way to “What do you think?”.

When we are doing future tracking surveys, we must be going more down the road of this
“What do you think?” emphasis. We will never do our job as a GMC if we are always reacting
back to complaints as the public perceptions. Why should we only ask the public, “What are
you going to complain about?”? We should do that to the professions as well.

We have to change our whole attitude on how we track, and I want to have greater emphasis
on “Tell us where you want to go in the future”. Some of this did it but, overall, the impression
is that we have this element of complaints from the public – and in some respects that is the
least interesting. The interesting bits are the way that they really would be involved in
regulation.

THE PRESIDENT: I see nods round the table and I suspect that might link in quite happily to
some of the Patient and Public Reference Group work, where we do want to have a longer-
term view as to what the public are thinking about issues of importance.

MR BOB NICHOLLS: I think that what you have said regarding the second recommendation
is a very good idea. I am very much with Fiona’s comment that the more positive and broader
the footing on which we do the tracking, the better.

My point is that there really will not be much difference in the results next year if we ask the
same questions, unless we do a lot of things in between. It seems to me that what we need
next is an action plan of the things we can do. We have discussed informally the importance
of reaching into the profession, into the public, in different ways. Chris was telling me of
something very interesting which is going on in Oxford – engaging the medical students. That
will be the next generation and the generation after.

We will be disappointed again unless we take quite a lot of action between now and the time
we next run a similar tracking survey.

THE PRESIDENT: I am sure we require baseline questions, but they need to be modified in
the light of changes in public interest and what is actually in the news.

Ruth, is there anything you wanted to add to this at the present time?

MS RUTH EVANS: Yes, briefly. We must remember that we called it an annual tracking
survey. If it is just a tracking survey every few years, then we ought to be careful about the
terminology and make sure we have some consistency in the intervening years with the
questions.
I would also support Fiona’s point, which complements very well the point I was making about testing out public attitudes on a whole range of ethical issues – and doctors too. I agree with that.

THE PRESIDENT: If there are no further comments, are we happy with the first recommendation? [Agreed]

I will read the second recommendation again. “To confirm that we should undertake a tracking survey in 2006 and then consider whether it should be undertaken annually.”

MRS ANN ROBINSON: I agree with the proposal that we review; that we do one in 2006 and then review where we go. However, I completely endorse what Bob has just said about the action plan and getting on with delivery.

The thing about an annual tracking event which tracks some core issues about us and our performance is that it forces you to take action seriously. Let it slip to every other year and we will be much more complacent. It really puts a lot of onus on us. And, yes, Brian was right when he mentioned that it may only move one or two points – but that is down to us. If we do not set our targets a bit higher then that, then we are failing.

THE PRESIDENT: Mine was purely the practical issue that it is now October and de facto it would be into 2006 before we were able to undertake this and get the results back.

MS SOPHIA BHATTI: On a point of clarification, even though the project began in 2004 the results were derived in 2005. So the next one, the actual survey part of it, would be within 2006.

THE PRESIDENT: I hope that does not undermine my consensus-seeking alternative here!

MRS GILLIAN CAMM: We have talked a lot this morning at different places about not just doing a tracking survey but having a clear vision about what we would like people to be saying, as well as what we get. We have talked about different audiences, and I am still toying with the idea of Ed appearing in a feature in Bella magazine! [Laughter]

THE PRESIDENT: This could be arranged!

MRS GILLIAN CAMM: I wanted to be clear about where does the accountability lie for bringing that back to Council, and when do we think that it is likely to come back?

THE PRESIDENT: I have not the slightest idea. Chief Executive, where does the accountability lie for this one?
MR FINLAY SCOTT: I have two suggestions. First, the responsibility for taking such steps as the Council thinks appropriate to promote the role and perception of the GMC lies with Andrew Ketteringham's directorate; but, buried in the papers somewhere – and it may even be in my report – is the fact that what was the Shipman Steering Group will continue as the Regulation Review Steering Group.

One of the things that we might take to that renamed group when it meets – and Ruth has reminded me that we must get some dates in the diary – is both in anticipation of the report from Andrew Foster and Liam Donaldson, and subsequently. That may be the place to first take some ideas, which we will then bring back to Council.

MS RUTH EVANS: Gillian has reminded me that there was another point I wanted to make, which relates to accountability. It is the publication of results. When I raised this you said, “In what way would you envisage it being published and now?”. We have talked outside the meeting – Ann and I, and Sophia – about possible ways. I think that somebody has suggested that the top-line results ought to be available in the annual report, which would make the annual report a really good read and give focus to a press release on the report – if we wanted to disseminate the results of the survey. It depends on the results themselves. However, there is an important issue about getting top-line results out there, in a form such that people who are interested can see them. When you say, “They are available”, that is not disseminating information in a way which is accountable to all our stakeholders. It is not good enough to do that.

THE PRESIDENT: The fact is, because these papers are in the Council papers they therefore are, in that sense, in the public domain. What you are talking about is making a much more concerted effort to emphasise them and to focus upon them.

MS RUTH EVANS: Yes. I used the term “published” but, whether as a stand-alone document or in another document, I think that it is an important exercise in accountability and will be informative for those people out there who are interested in how we are doing, and in what the public and doctors think about us.

THE PRESIDENT: I very much agree with that. It was the distinction between papers that are not available publicly and those which are. These are available, but not in that sense emphasised or focused upon.

MS SOPHIA BHATTI: Perhaps I may update Council members. I omitted to mention this when I introduced the paper earlier. As part of the press briefing in advance of Council we included a piece on the annual tracking survey and the key results that came out of that. So we have tried to get that out into the public domain in that way.

The suggestion that we should try to include the results in the annual review is very helpful. There might be a slight disjoint in the timing of the results and the point at which we go to publication of the annual review, but I think that it is certainly worth exploring to see if we could.
THE PRESIDENT: I had forgotten about the press conference. I guess that we will see the extent to which that has been picked up in the press this week and next week.

MRS ANN ROBINSON: I have one thing to say which none of you around this table will know, but if I do not say it then you will never know about this. I think that Sophia has been absolutely fantastic on this. She has done a first-class piece of work. She has gone beyond the call of duty. Her patience has been absolutely remarkable, and I think that we should all recognise the work that she has personally put into it. It has been great.

THE PRESIDENT: I think that we would all endorse that. Thank you very much indeed for saying it. Thank you, Sophia.

Do not go because, if we are content with the recommendation to have another survey next year and to review the situation, then I think that we can move on to the next paper.
THE PRESIDENT: This gives feedback from the seminar that we held in the autumn on the fitness to practise issues on the specialist register, and the fitness for purpose aspects of the specialist register. Richard will take us through it.

MR RICHARD MARCHANT: Earlier this afternoon we discussed the Section 60 Order, which completed the first part of the registration review. The bad news is that there is more, and that is the review of the specialist register. This paper contains a report of our initial stakeholder seminar which looked at the fitness for purpose of the specialist register, tried to flush out some of the issues and identify some possible options for change.

You will see that there were two, sharply divided schools of thought. On the one hand, there were those who felt we ought to adopt very much a minimalist approach. On the other hand, there were those who wanted the GMC to be holding more, better, and more comprehensive specialist information about doctors.

In addition to simply informing Council about the outcome of the seminar, the other thing we want to get out of this paper is a clear indication for what the way forward might be. The paper suggests that the way forward might be for us to look at holding more and better information. I suggest that we do not need to decide today what that “more and better” might look like. I guess that is a matter for the review to decide. However, a clear preferred direction from Council would be extremely helpful.

THE PRESIDENT: It is a controversial issue and it is one we need to get right. How we do it is something we can decide at a later date. At the present time, it is the principle behind this.

MR STEPHEN BREARLEY: I am sorry to be speaking on this at all. This is a project which is being taken forward under the auspices of the Registration Committee, which I think is how I ended up chairing the seminar that we had in October.

In the normal course of events, I would have expected to see this paper before it was generally circulated and to comment on it. Owing to the fact that I was away for quite a lot of November, I did not, and so I apologise to colleagues to be intervening now. I am also sorry to say that I have some concerns about the recommendation as drafted.

They stem from an appreciation which those not versed in the black magic of the registration process may not appreciate. We are being asked to agree that “the specialist register should in future carry a much wider range of information…” The specialist register has no physical existence, and whether something which does not physically exist can carry anything is an interesting philosophical point.

What the GMC has is a database of doctors known to it. Most of those doctors, but not all, are on the Medical Register. In other words, the Medical Register is a subset of the whole database. Some of those who are on the Medical Register are also on the specialist register; so the specialist register is a smaller subset of the database.
Where exactly do we put this additional information that is being referred to here? Is it going to be on the face of the register? It is only one database that we are dealing with. When people access the on-line doctor search, is this information going to be there, or are they going to have to go to another screen, or whatever? Why should it be that of all the doctors on the on-line doctor search those who are on the specialist register should have a lot more information about them than those who do not happen to be on the specialist register? There are rather a lot of practical problems to implementing this, quite apart from the issues of how this information is collected, validated, what responsibility the GMC bears for it, what indeed may be the consequences if it were found to be incorrect.

I wonder if I could ask that what we should do is to make a one-word change to this recommendation, and simply say that "the review proceed on the basis that the specialist register might in future carry…", which I think gives us the scope to see what the responses are, what the practicalities are, and what might be a practical solution to solving the problem which we clearly face with the specialist register as it currently exists.

**THE PRESIDENT:** I always get slightly concerned when we start arguing about a single word, so that the "might" and "should" issue is, in one sense, semantics.

**MR STEPHEN BREARLEY:** "Should" is a strong word.

**THE PRESIDENT:** On the other hand, we need to consider the downside to this. There are other organisations that are going to provide this type of information for groups of doctors who put forward specialist skills. If we do not do it, it will happen by default in other organisations. We already know, for example, that some of the specialist skills in ophthalmology might follow that route; and there are no doubt other pressures on us too. We have already talked about cosmetic and plastic surgery, where there are similar pressures, and the report from Harry Caton last year indicated that.

I fully accept that there are real practical considerations about how we do this; who is responsible for the data; whether we would adopt the North American practice of allowing the individual doctors to be responsible for the information that they put on but hold them accountable to us for the accuracy of that information. There are a whole variety of questions that need to be asked. The issue though is whether, as a Council, we think that we ought to be providing more information that might be useful to patients and the public on the specialist register than currently exists.

At the present time, as you know, people have to have their names on the specialist register to hold a consultant appointment; but thereafter it does not actually provide very much information of direct relevance. So there are issues here about how we develop the register, and I think that we probably should explore the possibility of making it far more useful and having greater data on it. However, we need to think carefully about how we do it.

**DR PETER TERRY:** I have certain concerns with this paper. I have absolutely no problem with more information being made available, but I question whether or not the specialist register is the vehicle through which this can be done.

As you quite rightly say, President, as I understand it the specialist register has some kind of statutory purpose and function, in that you can get on the specialist register either by completing a CCT or, like you and me, President, we are on it by virtue of the fact that we have been around long enough in secondary care; or, under PMETB, it is possible that,
without a CCT, a doctor will be able to demonstrate competencies and get on the specialist register that way. Once they are on the specialist register, by whichever route, they can then apply for a consultant post.

The number of specialties that are recognised, as I understand it, is listed in Schedule 3 of the PMETB Order. There is some issue with regard to European doctors who specialise in areas not included in Schedule 3 being able to get on the specialist register, and then coming and working as consultants in this country. You can look then at Article 14 of PMETB – I would be interested to hear what Peter (Rubin) has to say about this – and see how that fits into the whole statutory framework by which people become senior hospital doctors – if I could put it that way.

I think that is completely different from providing information on doctors in the way that Dr Foster does, if we think that is appropriate. I think that the two issues are completely separate. In particular, I personally think that at some stage this country, by virtue of Article 14, will have to modify the number of specialties that are listed in Schedule 3. I suspect that that process will lead to far more confusion than clarification in the mind of the public.

If what I have said has not already confused an awful lot of people, I think that it does demonstrate just how complex this issue is. I do not think that it is as simple as opening up the register and just putting more information on it.

THE PRESIDENT: Can I try to respond to that and see if we can separate the technicalities, which I do not want to get involved in at all? The specialist register, the legislation behind it, whether it is a good thing or a bad thing, are not for this afternoon’s discussion. There is the technical aspect that you have referred to – not what we are talking about at all.

Let us assume that stays entirely unchanged but, somehow or other, there is a second page. So I am on the specialist register as a renal physician, or whatever. There is a second page in which it says, “I no longer work as a renal physician; I am now a geriatrician”. I am responsible for that information. I have not sought to change the specialist register. None of the bureaucracy behind that changes. You have not lost the flexibility that the current system has, but it provides greater information for anybody looking up what I actually do.

The two things could be on the same database but they could be disconnected, so you do not have the fiendish bureaucracy required to keep this thing up to date, organised by the GMC, and at the same time it could provide information for patients – provided that the doctors keep the information up to date and they are held accountable to us for its accuracy.

There may be other ways of doing that, and it is certainly done that way in Canada and North America; but it does not follow that the technical problems that you have mentioned – which are real – necessarily impede the provision of greater information for patients and the public.

DR PETER TERRY: May I respond to your response? All I was saying was that I do not think this paper reflects the wider aspects of this, and I do think that they are relevant. I agree with you that there may be ways of doing it, and I agree that we should look at it; but what I would have liked to have seen in the paper is an appreciation of the much wider framework in which the specialist register sits.

THE PRESIDENT: If you use the dreaded word “should”, as I think you did, we probably agree. We need a further paper saying how that might be done, and we need to take this debate forward, but I would not like to preclude the possibility of doing that. Otherwise, large numbers of people who already decry the value of the specialist register will become even
more vocal about how completely useless it is in providing any kind of meaningful information to patients and the public.

We need to be aware that if we do not do this other groups will, and it will undercut the value of the information that we hold on our own register. The GMC register needs to be the database of doctors practising in this country. Without that, we have nothing of any great value, in my view.

I do not want to resolve this this afternoon. I want to start a discussion which says there is more to look at here. I think that simply saying this is too difficult, it is going to cause a straitjacket, and it is so technically difficult we should not even look at it, may not be the right way to deal with this.

DR PETER TERRY: I do not think I was saying that.

DR BRIAN KEIGHLEY: I do not support this paper at all, for several reasons. In my view, the specialist register came into being because of European directives and for no other reason.

On the horizon we have a GP register coming, and if you are going to apply this to the specialist register then you will have to say whether I am a GP with special interest in paediatrics, dermatology and gynaecology.

THE PRESIDENT: Yes.

DR BRIAN KEIGHLEY: You will have to say whether I am a trainer, a police surgeon; whether I get higher maternity payments. There is a whole myriad of information ----

THE PRESIDENT: I think that information should be carried on the GP register, but I want to be saying it. You will be saying it.

DR BRIAN KEIGHLEY: But this is the organisation that stopped recording my fellowship of the Royal College of General Practitioners and my Diploma in Forensic Medicine years ago. The arguments were that the register should be a register, and should not discriminate and give information. We now have a subsidiary register which we are saying we are now going to expand and put lots of information on: information where you cannot discriminate between types of doctors and the quality of the information. There is a publication out there called the Medical Directory.

THE PRESIDENT: There is the Medical Directory. Perhaps we could come back to the point you are making. The reason that we decided not to carry secondary qualifications was because we could not in any sense police them. That was the reason. It was not that they were of no value.

DR BRIAN KEIGHLEY: How can you police the information about whether I am a GP with a special interest in paediatrics?
THE PRESIDENT: No interest in policing it. You put the information on. You hold accountability to us for its accuracy ----

DR BRIAN KEIGHLEY: But my fellowship is a matter of public record, President.

THE PRESIDENT: …and it is not directly related to whether or not you are on the register; it is page 2 of the organisation. It may be that Council is going to throw this out. I do hope that Council does not throw this out. It would be a very self-defeating mechanism.

MR STEPHEN BREARLEY: May I try to be helpful? You showed no enthusiasm for my subtle amendment to the recommendation, so now I will give you a gross amendment to the recommendation. I suggest that the recommendation should be “To agree that the review proceed” – full stop.

THE PRESIDENT: I do not want to come back to semantics.

MR STEPHEN BREARLEY: Why do we need to be locked into a particular direction of travel on the basis of a very thin paper today?

THE PRESIDENT: But if we agree the paper today, then we come back with further details, because we feel that we should be providing more information for the patients and the public on the specialist register. Whether that proves practical is another matter, but it seems to me the principle is that we should be doing that.

MR STEPHEN BREARLEY: Forgive me making this into a conversation, President, but the term “on the specialist register” causes me enormous trouble, because I know that you cannot have something on a register which does not exist.

We have a database. You could link the database to other forms of information; but it is not on the specialist register. It is a terminologically wrong way of expressing things.

THE PRESIDENT: I am happy to accept that. It could very easily be turned into a register. The difference between a database and a hard register is pretty marginal.

DR ALEX FREEMAN: I found myself reading this paper and, all through it, asking the question why. Why are we thinking of doing this? How does it relate to our core business?

The specialist register is to register the Certificate of Completion of Specialist Training, shortly to become CCT, as part of European-wide harmonisation and mutual recognition of specialist qualifications. We have some difficulties here, because the UK list of specialties is not the same list of specialties in other European countries, and somebody could come to us with a European CCST in a specialty that we do not actually recognise in this country. So they are a specialist, but we will not recognise them in terms of being on the specialist register. So, to start with, there is a problem there already.
Secondly, there is the introduction of the GP register. In Europe there are two types of GPs: Title III and Title IV. Are we going to differentiate between Title III and Title IV on our GP register? How much information does the GMC need about an individual doctor to ensure that the GMC can regulate that doctor?

The GMC has not recognised my higher qualifications either. It has not managed to get the TGP next to my name on the register, even though I informed the GMC some years ago about that. Why does the GMC need to know that I do minor surgery and child health surveillance; that I have a particular interest in mental health issues? Why does the GMC need to know that, because in all of those areas I am practising within my field of competence as being a GP – which is what I do.

It would be lovely to expand all of our register entries and to put a little bit about our interests, a photo of our pets, and all sorts of things. It would be nice for doctors to add loads of things to their GMC register entries, but I am asking what the good of it is for the GMC?

THE PRESIDENT: I do not want to get into a dialogue with everybody around the Council table about this, but it is not necessarily a question of what the GMC needs to know; rather, it is the other way round.

DR ALEX FREEMAN: What is it to do with our core business? That is the question.

THE PRESIDENT: It is providing information to patients and the public that may be of greater relevance. It is not so much what we need; it is what we can do to help others.

MR FINLAY SCOTT: I was wondering whether I could suggest a possible way forward. Let me start by saying that I think there is a real danger of a circularity in the argument: “The purpose of the specialist register is X, therefore the only information you need on the specialist register is Y”. However, if you ask whether the specialist register – and Stephen will have to forgive my terminological inexactitude – could serve a different purpose, then perhaps it could carry, or the database that supports it and the screens that are displayed as a result of it could carry, different information.

Simply starting from where we have been and how we got to here in 1996 is not particularly useful. The specialist register was not created to record people who had acquired a CCST. It was slightly more subtle than that.

I think that we have to start with a question: can you find any single patient organisation or patient representative who will answer in the affirmative to the question, “Is the specialist register useful”? I have not encountered such a person. What I do encounter are large numbers of people who say, “The specialist register is of no use to me as a patient or as a member of the public. It does not provide me with useful information” – for example, that links the doctor with their current practice.

If that summary is correct, then we as an organisation have to face up to it. Of course we have to discharge our statutory duties, but a great deal of what we do interprets those statutory duties quite broadly. It goes back to 1858. It is to enable those in need of medical aid to distinguish the qualified from the unqualified. That is our root purpose. Having a meaningful register or specialist register is part of that.

My suggestion, therefore, is “To agree that the review proceed on the basis that the specialist register should in future carry a wider range of information than is currently offered, if that
can be shown to benefit patients, the public and employers of doctors”. So it becomes conditional on it being demonstrable that there would be a benefit to those constituencies.

THE PRESIDENT: Is that generally accepted, with that caveat put in place? There are many more nods than shakes, I think. Ed, are you going to shake?

DR EDWIN BORMAN: I am going to shake, because I am really concerned by the nature of the discussion we have had with regard to what we all appear to understand as the rationale for holding a register.

Finlay has indicated the primary purpose, namely, going back to 1858, to differentiate between those who were qualified and those who were not. Clearly in the intervening 150-odd years things have changed sufficiently for us to be able to allow patients, at their own convenience, to be able to pick up the internet-searchable or any other form of register and know that the doctor is qualified and, ideally, what they are qualified to do.

I am concerned that the discussion we have had suggests that the recommendation we have in front of us does not directly address that, because it narrowly looks at only one component of registration, namely the specialist register, whereas the issues that have been raised, equally applicable, would apply to all doctors on the register. So why should we choose only this narrowly defined subset, namely the specialist register?

I understand how we got here. There was a focus group with appropriate stakeholders, and I can understand how this specific recommendation arose. However, may I gently suggest that perhaps a more appropriate way of taking this one forward would be to take it away, bearing in mind the conversation that we have had, recognising that the fitness for purpose of the register itself needs reviewing, and that we may need to have a look at the sort of information that is provided more widely, across all relevant register entries – which Council may or may not decide at a later stage would be a helpful way forward?

I can understand the rationale from the patient, public and other organisations’ perspective. I have concerns about this particular recommendation. I am trying to dig us out of a hole.

THE PRESIDENT: That is fine and, in a sense, that is very helpful. However, the fact of the matter is that we have a group looking at the specialist register. That is where we are. We need to be able to give them guidance, and the Council needs to be aware of what we are doing.

In fact, the boomerang might be used the other way. What you say is correct but, if we agree this recommendation or something like it, the effect would be to have exactly that boomerang effect on the rest of the Council’s work.

I am reluctant, without a considerable fight here, to give the message that we do not wish to see more put into the specialist register – so that it really is of value to patients and the public.

DR EDWIN BORMAN: May I suggest that the way forward would be to say that, from this paper, we have recognised that there may be wider implications for register entries, and that we would need to take this away in order to consider the wider implications and whether perhaps we need to apply this approach more widely. For those who are sceptical about this approach, that would give the opportunity for them to consider this issue more fully. For those who are more keen, they would have the opportunity to justify it but in a broader context.
My issue is that what may be applicable for the specialist register may well be applicable more widely; but I am not convinced that this narrowly defined approach is the best way forward at this stage.

DR PETER TERRY: I am reasonably happy about what Finlay has to say, with Ed’s modification. I think that this is in relation to all doctors rather than just a subset of doctors.

I suppose what really set the alarm bells ringing was the suggestion that it would be up to the individual what they put on, effectively, what is the GMC-owned register. I am happy that more information goes on about all doctors. I am happy that that information is made available to the public; but I absolutely want that information to be true. The whole purpose of the register right from the start was to prevent quackery, and I can see us introducing it again if we simply allow people to include on the register whatever they fancy.

I was not thinking about photos of my pets or anything like that, but if you look at some of the organisations – without mentioning any names – that were party to this consultation, it is clear that some of them have an interest in publishing quite a lot of information, and some of them are very closely related to publicity and publicising various activities.

I think that, as the guardians of the register, we must make sure that it is used for its primary purpose; that is, in many ways, to provide as much information as possible – but that absolutely has to be true. If we take on that responsibility, then I am much more content with the proposal. That is not how it is presented, however.

THE PRESIDENT: And that is not how I would wish any of this discussion to go forward. If you go down that line, you create an enormous bureaucracy. In my view, it is much better that, if we do go down this route, the onus of responsibility is put back on to the doctor to ensure that the information is accurate. Of course you put guidelines as to what goes on, so that you do not necessarily have your pet cat or whatever else there.

The responsibility for the accuracy should not devolve back on this organisation. Otherwise, you create not only a huge bureaucracy but you prevent the very flexibility that the specialist register has allowed in recent years, where people can move from one employment to another. We would not want to stop that. However, we do want to give accurate, reasonable information to patients and the public – in a way that the specialist register simply does not do at the present time.

It is how you balance these things. I am not suggesting today that I have the right answer, but we need to look at that. I would be sorry if we lost the momentum on the specialist register because we were going to take it on a broader front. I am sure that it ought to be on a broader front. The GP register, which does not yet exist, should have the same information in due course. We should not slow up the momentum here. There is a need. The plastic surgery, cosmetic surgery, and ophthalmology work shows that the public expect further information from the specialist register than we are currently giving it.

VERY REVD GRAHAM FORBES: I am not a member of All the President’s Men Fan Club, but there is a silent majority here, or certainly in the world, that wants the information there. I cannot see why we should not enable patients, public, et cetera, to have access to it. I strongly support what you are suggesting.

It has been interesting that those who have been called have all taken one line. Rarely do we split, doctors on one side and lay people on the other, but I suggest that on this one we clearly are splitting that way. [Several members: No]
PROFESSOR CHRIS BULSTRODE: I think that this fits with transparency, openness and giving information, and I would strongly support it.

DR JOAN TROWELL: I was going to challenge Revd Forbes on the “split”. This paper demonstrates to me what I already know, which is that at the moment the specialist register is not fit for purpose and it does not reveal the information people need. I know that my details are probably actively misleading.

I think that we are committed through our original foundation, as it were, and the Medical Act to providing information which enables the people listed here. I would also remind people that this is merely an agreement to allow a review to proceed. It is not saying what will go on, and so on. It is permissive only to the extent that we want you to do further work. I am assuming that, in the best traditions of this Council, we will get more detailed papers and reports back.

It seems to me that there is probably also a need for a Council seminar, to educate us all about some of the niceties of this, and to allow us to think round the issues in a way that is not quite as confrontational as this debate has been.

While I hear the anxieties of my colleagues, I would like to suggest that we do accept Finlay’s modification of this and allow the work to proceed, on the understanding that we will be further consulted about any implementations that are planned.

THE PRESIDENT: And on the basis that we can show some demonstrable benefit.

DR JOAN TROWELL: Yes. That was the modification I was accepting.

MR ALAN HARTLEY: For the first time in many years I am in a situation where I am sitting round a table at the GMC, and I am thinking, “Dare I let them know that I am a member of the public and a member of a patient group?”.

I was at the seminar, and it was a difficult day. However, the recommendation, with Finlay’s amendment, is straightforward. Like it or not, you are in a situation – “you” being the GMC – where the public demand more information.

The changes which have happened within the GMC since my involvement – which I was shocked to learn recently was since 1998 – have been huge, none of which as a member of the public I expected to happen. I did not expect them to happen, but they have.

This is simply asking for the review to continue. It is not coming up with any firm recommendations. The seminar was a very difficult day, and I was there wearing my Patients Association hat. It was clear after that day that there needed to be a lot more information about why the specialist register existed, that it was because of EU regulation, et cetera.

I would therefore urge the Council to continue with the review. There is a clear need for a wider discussion as to what the purpose of it is, what the EU decide should be its purpose, and so on. Please support the recommendation.

MR STUART HEATHERINGTON: Paragraph 7 of the paper refers to our November meeting last year, when we agreed to “identify further ways in which we can add value…”. The last
sentence there says, “The question of precisely what information will add value is properly one for the review to determine”.

The proposal, amended by Finlay, is talking about work in progress and work should progress. Just get on with it. I do not know what all the fuss is about!

THE PRESIDENT: Finlay has made some indecipherable changes to the recommendation. Perhaps it would be helpful if he read them out, and then we can see if it would be acceptable to us.

MR FINLAY SCOTT: I have a new, expanded version in the light of contributions from members. It is,

“To agree that the review should proceed on the basis that registers, including the specialist register and GP register, should in future carry a wider range of information than is currently offered, if that can be shown to benefit patients, the public and employers of doctors”.

THE PRESIDENT: How are we doing with that? [Agreed] Does anybody feel that they cannot live with it?

MR STEPHEN BREARLEY: I am not sure we can do it.

THE PRESIDENT: I think we have agreement on that. That is the end of the programme.
Tuesday 31 January 2006

5a. Collecting and using information about doctors’ practice

THE PRESIDENT: This is a separate paper from the one we discussed last time, but there are clear links to the discussions we had then on the registers—not just the specialist register but the other registers—and it links back to the advice we gave to the Chief Medical Officer on his call for ideas, about the information we would require for revalidation, for issuing a licence, and the concept that we would want to know at an early date about the scope of practice in order to make decisions on risk, and which doctors should be put through revalidation and at what sort of interval.

This paper brings together these different concepts and it is based on the Regulatory Impact Assessment paper that is in front of you.

MR PAUL BUCKLEY: As the President has said, the Council decided in September that, subject to a Regulatory Impact Assessment as a condition of being granted a licence, doctors should provide information to us about their practice. This is a progress report on developments since then.

I should stress that the document at Annex A is not the finalised Regulatory Impact Assessment; it is an initial draft. It does not at this stage attempt to answer questions, such as exactly what information should be collected; how long it will take for doctors to provide it and for the GMC to process it; what the costs are, and so on. The reason for that is, as we were hearing in the last paper, there is an important issue with respect to engagement in relation to this proposal. It is not for the GMC, acting alone, to decide all of these matters. We need to talk to and consult with stakeholders, developing this policy as it is taken forward, rather than coming to you with a fully worked-up proposal that we would then be intending to impose on the outside world. This is very much a first go, therefore, at what some of the policy issues are; but there are a huge number of practical and operational challenges that will need to be addressed if this is to be delivered.

Keeping this at the higher level of policy, there are three main policy strands in play. First of all, the proposal to link information about practice with licensing rather than, as originally planned, with revalidation. Clearly, this opens up the potential to “operationalise” revalidation in a different way than originally planned, in particular by enabling the prioritisation of the revalidation of doctors outside approved environments. It does have that potential.

Secondly, the proposal is relevant to the new legal provisions in relation to indemnity and insurance. These will place a duty on doctors to have appropriate cover. The GMC will have powers to specify what constitutes appropriate cover, and powers to specify what information doctors need to provide to the GMC to enable us to decide if they do in fact have appropriate cover. It does not necessarily follow that this will mean that doctors will have to describe to us the scope of their practice, although clearly that is one option.

The third policy strand relates to the decision Council took in December that our registers should in future carry a wider range of information than is currently offered, if that can be shown to benefit patients, the public and employers. Self-evidently, we cannot provide a wider range of information unless we have obtained it in the first place.

I think that there is an additional underlying point. Our Register is the only database which includes every registered doctor in the four countries of the UK. Increasingly, as there is
greater choice and diversity of provision, even within the NHS, patients will be seeking more information about the doctors treating them. It does not follow that the GMC should be the main repository of such information, and it also does not follow that all the information we provide would be part of the registration record proper. There may need to be a distinction between what is registration information and information which is accessed via our registration database. However, the fact that we do have the Register certainly gives us a unique role and a unique opportunity.

That is the context. There is clearly a great deal of further work to do. What we are seeking today is an endorsement of the general direction of travel and agreement to hold a seminar with stakeholders, so that we can understand better what their needs and expectations would be, and begin to overcome the many practical challenges that we will face.

THE PRESIDENT: I guess the new bit for Council members relates to the indemnity requirement within the Section 60 Order. I think that was discussed at the Registration Committee last week, as well as the rest of this paper. Do you want to amplify that, Stephen, or tell us what happened last week at Registration?

MR STEPHEN BREARLEY: I will try not to duplicate too much of what Paul has said, because I think that he has given an extremely fair and comprehensive introduction to the paper.

The paper could almost have been a paper for information. It is so consistent with previous decisions of Council and the direction of travel to which I think we have all signed up. Presenting it today, however, does give the opportunity to inform members about how things are developing and, once again, to seek your support.

The subject matter of the paper can perhaps be seen under two headings, namely principles and practicalities. The principle that we need to collect more information and that the right time to do this is at the point of issuing a licence is difficult to dissent from. There are, as Paul has said, three issues which make it necessary for us to move in this area, one of which is the provision in the Section 60 Order requiring us to be satisfied that doctors have adequate and appropriate indemnity. One is our policy that we wish to move in a direction of risk-based regulation, and one is the work that we are doing on the specialist register—which again is likely to involve knowing more about the people we register.

The discussion at the Registration Committee last week, as perhaps you might expect, focused somewhat more on practicalities. It is fair to say that this work is at an early stage, and we do not yet have answers to questions of what information we should collect, how much information we should collect, how often we should collect it, how we should collect it. Nor do we have answers to questions about what information we should publish, how we should publish it, to whom we should publish it. There is therefore a lot of work to do to come up with solutions which are valuable to the wider community, efficient, cost-effective, proportionate and practicable, and that is work that will be going on over the next weeks and months.

In the light of all of that, I trust that Council will give its endorsement to the principle that we need to collect some more data at the point of licensure—though I cannot yet tell you what. Clearly this is an issue in which a lot of constituencies will have an interest.

I was interested in the discussion about the involvement of people from outside the Council in policy development. Certainly within the registration sphere our practice of late has been to have seminars and to invite lots of people along. They seem to work very well, and that is what we would like to do in relation to this piece of work as well.
THE PRESIDENT: As Stephen was saying, in a sense what you have here is a continuation of that which we have agreed before. It has the additional impetus of the requirement on us of the indemnity proposals in the Section 60 Order, and the concept that we need to do further work on this and to come back to you to keep you informed about it, presumably both before and after the proposed workshop.

This is not a minor piece of Council business; this is a hugely important piece of Council business which also links directly into almost all of our other activities.

DR PETER TERRY: I would certainly endorse moving forward with this, as we have already suggested. However, referring to the first recommendation on page 4, Option 2, relating to the draft initial Regulatory Impact Assessment, I may have misunderstood this—although I have read the paper reasonably carefully. I could see very little in the paper about the service risks associated with such an initiative.

Presumably that may come out in the consultation, but it strikes me that there may be some service implications, depending on how much information will be collected. I think that we need to be careful about that, and build it in at a very early stage. Essentially that is a service impact risk that we should be fully aware of, because there will be comments, both from the profession and the employers, about the consequences of what we are trying to do.

The second point is in relation to paragraph 16. It strikes me as something we have got into trouble with before, in terms of the web-based doctor search. It is not so much the information that we hold but the possible implications of information that is not there. We should make sure that the Registration Committee is aware of that point. With an academic clinical pharmacologist—with no other information—a conclusion could be drawn, for instance, that that individual is heavily involved in animal experimentation or something like that, and thus lay themselves open to certain risks. It is that side of things I would like to make sure that we are aware of.

Finally, referring to page A1, paragraph 2.2(a), I wondered what we meant by “non-medical based practice”. I could not think of an example. Most things that doctors do can be related to medicine. We are the General Medical Council and we would be interested in that kind of information. I just wondered what that meant.

THE PRESIDENT: I think that, when we were looking at some of the revalidation pilots, it was surprising that doctors were submitting information on what they did that bore absolutely no relationship to medicine in the broadest context. I suspect that is what that means. You could argue, at least in that context, that revalidation and the holding of a licence would not be required; whereas this Council has taken the view that clinical practice, or medical practice more broadly, would require a licence.

That was the first point you made. I am absolutely seized of the importance of your other two points, not least making sure that our impact does include the impact on service commitment. If we do not do that, I think that we lose credibility with employers, the profession, politicians, and so on. Maybe Paul can answer whether that was taken into account with the draft impact assessment.

MR PAUL BUCKLEY: It has not been reflected in detail, as you will have seen, but certainly that is one of the reasons why we need to have the seminar and engage with stakeholders in the way that we are proposing.
THE PRESIDENT: In terms of advice on how we submit information that does not cause greater problems, along the lines you have outlined, clearly it is essential that we take that one forward.

SIR MICHAEL BUCKLEY: As Stephen said earlier, a lot of this is just continuing Council policy but, so far as I know, the proposition that we should take on responsibility for indemnity is new. I would like to know rather more about what it is that we may be letting ourselves in for.

At one extreme, it could be the sort of job that a Post Office counter clerk does when you go to tax your motor vehicle. He just looks to see if there is a certificate of insurance, is it valid, does it cover the vehicle, and so on. The way I read the paper, however, it looks as though we are being asked to do a lot more than that. It looks as though we are being asked to lay down the appropriate cover. That will involve us in a lot of argument between the medical defence organisations, the profession, the Government, and so on, and to arbitrate in a matter on which we have very little expertise and, arguably, very little locus.

Secondly, it looks as though we are being asked not simply to take a straightforward thing from an insurer saying, “Yes, I certify this is in accordance with the regulations”, but actually to look at the policy. That will be a huge bureaucratic burden. What are we letting ourselves in for here? It seems to me that the starting proposition is that it is for government—responsible for social policy—to determine what is an appropriate level of cover, for the insurers to certify that that cover is available, and then we can take it on as part of a reasonably straightforward matter of licensing. At the other extreme—which is the way that I read the paper—I think that we are letting ourselves in for something that could be very difficult indeed.

THE PRESIDENT: I think the point is that we did not volunteer for this; we were “pressed men”, if that is an acceptable phrase these days. It was something that appeared out of the blue and about which we had not sought legislation. The way in which we will seek to implement that is critically important. We must keep out of the kind of long grass that you are describing. Perhaps Finlay or Stephen can take this one forward.

MR FINLAY SCOTT: I know that Stephen has expressed very similar concerns, and not surprisingly. As the President says, this is not something of our making. I suppose it owes its origins to one or possibly two cases in dentistry, which led the minister responsible for the General Dental Council to impose a similar requirement upon the GDC through their first Section 60 Order, and now the intention is to impose it on all the other healthcare professions through Section 60 Orders. We are where we are, therefore, not because we chose to be.

Michael is absolutely right. By way of background, the power in the Section 60 Order is essentially a duty and a power to make regulations, and it is the regulations which will contain the detail. In our response to the Section 60 Order—the draft consultation which is going back today—we will very much want to reflect the concerns that Michael has expressed, and that indeed other members have expressed.

In addition to the bureaucratic nightmare that could unfold, we also need to recognise that if we are taking a view about the adequacy and appropriateness of something which subsequently turns out to be neither adequate nor appropriate then, on the face of it, we have placed ourselves in a position of some jeopardy. We need to reflect all of that in the response which will be going back today.
THE PRESIDENT: I am not sure if that is enormously helpful, Michael, but it does describe where we are. Stephen, do you want to add anything to it?

MR STEPHEN BREARLEY: The first thing I was going to say, President, is that I am very impressed with what has been said by those who have contributed so far, because they have gone straight to the problems that the Registration Committee is also concerned about.

Yes, there is operational risk, Peter, which is why there is so much more work to be done on what, how much, and how this information will be collected and handled. Yes, Michael, this indemnity issue is a real risk for us. As the President and the Chief Executive have made clear, this is something which has been imposed upon us in the Section 60 Order, and we have to work out how to handle it in the most efficient, effective, and risk-free way. These are matters which we shall be grappling with in the very near future.

PROFESSOR CHRIS BULSTRODE: This is a slightly different issue. This paper seems very clearly to explore the dynamic tension between the right of an individual doctor to the privacy of their address, whether they operate on animals, and all sorts of other things that might expose them to unfair activity, and the need of a regulator to have adequate information about that individual, to ensure that they know who they are talking about and that that person is performing to standard. It seems to me that that border is moving in our society at the moment, and therefore we need to be light on our feet.

There seem to be three levels of information that we require. We require the information for registration, which is absolute. Secondly, we probably require information for licensing. Thirdly, we might think about putting in some optional fields at this stage, to allow doctors to present extra information if they choose to do so. We could look and see how much doctors choose to put into the open domain and what happens to that information. For instance, if you were a single-handed practitioner in private practice you might choose to put quite a lot of information in there, to reduce your risk of being heavily revalidated. We might see how the field moves in a more flexible way, given that it is very much a moving target at the moment.

THE PRESIDENT: Not to rehearse the debate we had last time round, but my guess is that we would need to provide some kind of framework within which that information was provided and not leave it just free-flowing. But, yes, I think that is absolutely right.

We will come back to the issue of addresses in the next paper, because there may be a way through that slightly difficult problem.

PROFESSOR SIR ALAN CRAFT: I would like to stress the importance of involving the employers and probably the colleges in any debate that we have around this. I think that it has become increasingly clear that NHS employers will not necessarily follow the rules in the future of appointing either trainees or consultants. They will appoint whoever they want to do the job. They are turning to the colleges probably to credential people, not only at a specialist level but perhaps also at some lesser level.

I think that we need to be aware of what the employers want and need, and somehow react to that and make sure that we know what is going on. My own view is that I do not think that we actually can maintain a detailed specialist register because, once people are on the specialist register, their work will take them in all sorts of directions. We probably need to leave it to the employers eventually to make sure that someone is competent to do whatever job they are employing them to do. For the GMC to do that would be extremely bureaucratic.
THE PRESIDENT: That is the debate we had last December, I think, which I am keen not to reopen. It is what Chris is saying about the balance: to what extent can that be a responsibility that is shared with the individual practitioner, as opposed to a bureaucratic imposition from a body like the GMC? That is where we need to have the discussion. I would prefer not to have it today.

PROFESSOR SIR ALAN CRAFT: But making sure that we bring in the employers, because in all of this debate, particularly about training and what sort of person we need for the future, they have left out. I think that we need to bring them in.

THE PRESIDENT: I very much agree with that. I am sure that is absolutely right, and they need to be part of the workshop that we are talking about.

The recommendations are benign, I think. The discussion is more important than the actual recommendations. The first one is to endorse. I guess we have endorsed the direction that we are moving in.

The next recommendation is to agree that we should hold some kind of workshop with our partners, including employers or healthcare organisations, to take this forward. Are we content? [Agreed]
Outcome on strategic options for undergraduate medical education

PROFESSOR PETER RUBIN: The last time Council had a look at this was in September in Edinburgh. Since then, we have undertaken a major consultation, contacting all the usual individuals and organisations that we contact under these circumstances. In addition, we have been round to all parts of the UK in person – myself and your colleagues in the Education Section – to hold local meetings. In paragraph 17 of paper 4a we have listed the individuals and organisations that either I or your colleagues in the Education Section have been out to meet personally. So this has been a very extensive consultation.

We looked at a few areas. One, whether there should be a national exam. Second, whether the GMC should register medical students. The third – which is more of a regular item – was to review our guidance for undergraduate medical education. I intend to take each of those one at a time and pause between each of them, to see if Council members have any comments.

With regard to a national exam, we offered various options: ranging from staying where we are, through to strengthening the external examiner system, up to having a new national exam.

To put this into context, there are national exams up to the point of entry to university and there are national exams following on from graduation from university. What is different is at university, where each individual medical school sets its own exams to ensure that the graduates have met our requirements as outlined in *Tomorrow's Doctors*. The external examiner system is meant to ensure that every medical school will do this to the same standard.

The responses we had were very varied and there were strong feelings on both sides of the argument. All the detail is here in the papers. Reducing it to its most basic level, there was very strong opposition to a national exam coming from the BMA Students Committee, the BMA Junior Doctors Committee, and many of the royal colleges. Significantly, there was strong support for a national exam coming from patient groups and from lay members of Council. As an independent regulator, we take that on board very seriously.

To put this into context, the present arrangement, whereby universities do their own thing with regard to exams, does not seem to be producing major problems. A survey done about six months ago looked specifically at which new doctors were causing concerns on the basis of their knowledge or their skills four months into the job. Amongst 5,500 new UK graduates, 16 were causing concern. One would have to ask whether any new system would come up with any improved outcome over and above that. On the other hand, there is the issue of reassuring the public that every new doctor graduating in the UK has met the same common standard.

What we propose to do over the coming months is to take forward the policy implications of doing a number of the recommendations that came out of this initial consultation. Taking forward the policy implications of strengthening the external examiner system – what would
we mean by that and how would it work? Also, taking forward the policy implications of introducing a national exam – what would it mean? Who would do it? How much would it cost and what would be the added value? We intend to do that over the coming months.

That is where we are with the national exam, and we would be very happy to answer any questions that Council members have.

THE PRESIDENT: It is really a statement of where we are with the policy at the present time.

PROFESSOR CHRIS BULSTRODE: Could I make a general comment about this paper first of all? I thought that it was absolutely fascinating, and I would like to congratulate Paula and Ben on what was a huge amount of work to bring this all together and to present it so clearly.

However, I thought that the interesting part was the part that Peter mentioned just now: that there were very strong but opposing views on several issues that were brought up in this paper. I wonder whether the next stage of this project is to unpick why there were such strong and opposing views. It seems to me that there are two possible diagnoses. One is that there is a complete dearth of information, and so people were just arguing non-rationally and emotionally on what they felt. The alternative is that there is information available but some people did not know about it. We certainly seem to have a polarity between the medical educationalists, the undergraduate teachers and some of the postgraduates about what is going on.

It seems to me that this is the start of some work that we now need to discuss and to do – pick out the questions we think are interesting, unpick them, and find out why. It seems to me that it is core business for the GMC as a regulator, both to make sure that we have the information available on which rational decisions can be made and to make sure that that information is disseminated properly.

I certainly had a sense all the way through this paper that some of the very strong views can only have been based on ignorance. There could have been no other possible explanation for that position. I will not go into any of the particular ones.

As you probably know, we organised a debate in our medical school about the national exam. The dean said that he did not understand why we were doing this, because he knew what the students wanted. Over a third of the students turned up at lunchtime during exam week to debate. There was a fascinating and very exciting debate, and the vote was very strongly opposed to what the dean had said the students would vote for. So there was a dearth of information and also a dearth of knowledge about that information.

Also, the students then came up afterwards and said, “This is absolutely fascinating. Is this what the GMC does?” I said, “Yes, on a daily basis we are doing this sort of thing”. They were very impressed. I think that there is therefore some ground to be made there. However, this is the start of a big project, not the end.

THE PRESIDENT: Are you going to tell us what either the dean or the students thought?

PROFESSOR CHRIS BULSTRODE: The dean said that students were totally against a national exam. It was 70:30 pro a national exam, after the debate – which surprised me too.
DR EDWIN BORMAN: It also surprises me. Like Chris, I was concerned and struck by the discrepancy between different groups and their responses.

Broadly speaking, the more the profession looks at the issue of examinations, the more the profession recognises that examinations are helpful for looking at only one aspect of what it means to be a doctor. Hence, it is a limitation. If you want to see what a good doctor is about, it is more than just what an examination can assess.

It may be said that an examination at the end of an undergraduate period is more appropriate for looking at knowledge base. However, I would suggest that, among students, we would want to look at the qualities of what makes a good doctor – even at that early stage – rather than what makes a doctor who has read all of the necessary books and has incorporated that knowledge.

What disturbs me is that that is not what we are finding coming from the public and from other groups, where there still seems to be the view that examinations are the means of determining what will make a good doctor. Somehow we have to get the message over that it is part of the process, but actually the GMC’s thinking has gone way beyond that and what makes a good doctor is much more than simply what can be assessed by an examination. It is a key message for us to get over, and I very much hope that Peter Rubin’s group will take that into account in terms of its thinking.

It may cut across what he has indicated he will be doing as part of the continuing work, but communication and why we may decide not to have a national examination clearly will be a major task.

PROFESSOR SIR ALAN CRAFT: I want to say something about the need for a national exam. There are two purposes as I see it. One is to try and make sure that there is some sort of standard across all the medical schools. There is no evidence that there is anything wrong with the standards across the medical schools with the system that we have at the moment.

From the college’s point of view, however, what would be enormously helpful would be to have some sort of ranking examination, taken before people apply for specialist training. It means that it probably has to be at the end of F1, which is what the GMC look after.

If you talk of a ranking exam, that gives people worries; but at the moment there is no way that we can pick people to go into specialty training other than their saying, “I fancy doing that”. They have nothing to back that up in terms of what their performance is like.

From the Academy and from MMC, it would be enormously helpful to have some sort of ranking examination. This is an incredibly important piece of work to take forward, but I wonder if we could get the chairman of the Education Committee to talk to the chairman of PMETB, and perhaps get the two of them to work together.

THE PRESIDENT: What you have very helpfully done is to cross that divide. Peter was talking about the national exam at the end of the medical school years. You have moved into the postgraduate arena.

PROFESSOR SIR ALAN CRAFT: But the exam would have to be in the immediate undergraduate arena.
THE PRESIDENT: I am not quibbling with the concept; I am simply asking if Peter would pick up the broader question, which goes beyond the national exam at the medical school level into the topic that you have picked up, because it feeds directly into the next paper that we are looking at.

MRS ANN ROBINSON: I want to support Chris’s suggestion that a bit more work is done to find out what is going on here and why these different views are coming forward.

I also want to pick up the point made earlier by Rachel on the tracking survey. She made a very good point on the tracking survey which seems to be at variance with what Peter has just said. The tracking survey demonstrated that there are real concerns amongst senior doctors about the competence and ability of new doctors. I think that we ought to have a look at that, to find out what the case is.

I therefore back what Chris has said about the need for further work.

THE PRESIDENT: No doubt Peter will answer this, but the evidence base for much of this is probably quite weak, I suspect.

PROFESSOR JANET HUSBAND: I would like to support Alan’s view in relation to selection into specialties. I would also make a point about future methods of learning. E-learning is a fantastic opportunity to develop uniform standards, not only of education but also of assessment. I think that we ought to grab that opportunity.

We are certainly developing it in radiology, and it is already proving to be a highly effective method. I wondered if you had looked at that.

DR ARUN MIDHA: I would support Janet’s view on the e-learning side of things. From the lay perspective, my understanding is that there has been a huge amount of work in terms of developing the curricula – MMC, et cetera – but it is how you actually deliver the curricula to a disparate group of thousands of doctors across the countries, et cetera. E-learning is potentially a portal or route to doing it. Is there evidence that it works or not? That is a major project that we could be developing fairly quickly.

THE PRESIDENT: Peter, do you want to respond? I think that you ought to stray into PMETB territory, where that is relevant.

PROFESSOR PETER RUBIN: I think that the first thing to do is to assure Council members that the points raised have been raised with us during the consultation and they are part of what makes this so very interesting, as well as so very important. We will be taking forward all these issues in the further work on this area.

We do have a little insight into why some people said what they said. For students, for example, it was issues like, “We’ve got plenty of exams as it is, and who is going to pay for it?” For the patient groups, however, it is an assurance that there is a gold standard, and most of us round this table can understand that. I think that it is very important that we do now get into this in depth and work out the policy consequences of going whichever way we go.
Perhaps I may make a general comment about leading opinion. It is particularly relevant with this topic. The art in leading opinion is to get the judgment just right, so that you are there to tip the balance between the “no” and the “yes” when the time is right to tip the balance.

On the one hand, you do not want to be so far ahead of opinion that the idea is way before its time. I made that mistake, for example, when some years ago I tried to persuade medical schools that we needed a national entrance test to medical school. I was in a tiny minority and it got nowhere. What is happening this year? There is a national entrance test to medical school. I just timed it wrong. On the other hand, you do not want to get the timing so wrong the other way that you are behind opinion and you are reacting to what is going on around you.

With a national exam, I am absolutely convinced that we must get right into this and understand the issues in detail, so that we are able to present the arguments for and against, as and when the time might be right to present those arguments.

**THE PRESIDENT**: When you are talking about a national exam, what time are you thinking of? Is it the end of undergraduate years? Is it into F1?

**PROFESSOR PETER RUBIN**: I am conscious of the fact that when we did our review on the PRHO year, which was not that long ago, there was an overwhelming resistance to an exam at the end of what is now F1. However, times move on, and so on.

One of the most important things that we will need to do in the work coming up over the next six months or so is to ask this question. Are we going to go the US medical licensing exam route, where there is a year two, a final year, and then a first year after graduating exam, or are we going to go for one exam and one exam only? If we do so, should that be in the final medical school year or around the end of F1? There are strong arguments for and against both. One of the most interesting bits of this is to work those arguments up.

Those of you around the table who have been aware of all the difficulties of the selection into the Foundation Programme – quite apart from the selection into specialist training – will immediately see that there are some advantages in having a national exam at the right time.

**THE PRESIDENT**: There are several dangers in this. One is that you could end up with multiple exams at yearly intervals for students. We need to avoid that. So making sure that we have the appropriate system in place would be enormously helpful, I think.

**PROFESSOR PETER RUBIN**: And to recognise what Ed has said, which is so very true: that there is so much that we want to know about a medical student that an exam would not show us. Equally, there is a knowledge and skills bit, which an exam could test very well if it was done right.

It is a very interesting area, therefore. There is a major piece of work for the Education Section coming along.

**THE PRESIDENT**: With our interest in assessment straddling so many aspects of GMC activity, it is core business for us and not just the Education Section. We can think of other sections of this organisation – PLAB test, Registration, Performance and Fitness to Practise –
all of which are relevant to this discussion.

If there is nothing further on the national exam, can we move on?

**PROFESSOR PETER RUBIN:** Registration – whether the GMC should register students. We used to, and we stopped doing so in 1940.

Until the late 1990s, most medical schools had no mechanism to remove from the course people who were a risk to patients. Provided they passed their exams, they continued on the course. In the late 1990s, I chaired a joint committee between the GMC, the medical schools in universities in the UK, which looked into this. That gave rise to a legal report, which in turn gave rise to every medical school in the country introducing a fitness to practise committee.

We knew when we were doing this that the fitness to practise committees that were being introduced were imperfect. They were imperfect for two reasons. One was that most medical schools are at universities that are ancient or very ancient, and their statutes are ancient as well. These universities were very constrained as to what they could do. A further reason was that there was varying enthusiasm for the concept of universities getting into conduct issues.

That is the past, therefore, and where we are now. The driver for looking at whether the GMC should register medical students comes not from within the GMC; it comes from the medical schools. The medical schools are concerned – and we knew this was a problem when we introduced this – that there is not a great deal of coherence about the way fitness to practise procedures are conducted in medical schools around the UK. We cannot at the moment guarantee that somebody in Exeter and somebody in Aberdeen will be treated in the same way for the same alleged offence.

Also, I am pleased to say that conduct issues that are of sufficient concern to lead to a student coming to a fitness to practise committee are actually quite rare, and so an individual medical school will not build up any corporate knowledge. The universities themselves are therefore very interested in the GMC taking this on – not to mention the legal costs.

We have taken a look at this as part of the consultation. The options were: to stay as we are, which no one really agreed with – everyone agreed that something must be done; to come up with clearer guidance to move on from where we are at the moment; or to have the GMC registering students.

When we are talking about the possibility of the GMC registering students, I must emphasise that we are not interested in the GMC getting involved in the foolishness or over-exuberance of young people. We are talking about the safety of the public here. If we were getting involved, therefore, it would be at one end of a spectrum.

Again, there were very conflicting views and, again, we are taking forward the policy implications of, “If this, then that…” – the practical consequences of doing these things. We are, however, taking forward what seems to us to be the most practical of the recommendations that came out of the consultation. A joint group between the Council of the Heads of Medical Schools and the GMC Education Committee is already in operation. It is very well attended. People clearly take this very seriously and it is a very well attended group. We are in the process of working up new guidelines that would make the existing fitness to practise procedures more robust.

That is happening in any event, but we are also taking forward the policy implications of whether or not we should be thinking about the GMC registering medical students.

**MR ALAN HARTLEY:** The general public will automatically assume that the GMC do this.
They would not expect it to be shared out; they would expect the GMC to be already looking at fitness to practise where students are in a medical setting or a hospital setting.

I must admit that when I read the paper I was surprised that the GMC did not do this. Even though I have been involved for a long time and assumption is a dangerous thing, I had assumed that that would automatically happen.

THE PRESIDENT: There is no question that we need to influence what is happening and have a say in it; I suppose that we are talking about how best to do that.

DR JOHN JENKINS: I think that this section again exemplifies what Chris was talking about earlier. The responses of people to the register issue seem to be largely based on their interpretation of what the register might end up being used for. I think that we need to work to tease that out.

If you look at some aspects of what we are talking about, there are very strong and possibly overpowering reasons as to why we should think of moving in that direction, but not if it was being used for other purposes.

I would like to draw attention to a couple of other things in this section: not to suggest that the Education Section is not already aware of them, but because I think that they are important.

First, in paragraph 41 there is a reference to the transfer of information between undergraduate education and Foundation programmes. As part of any robust mechanism of dealing with fitness to practise we have to have a system whereby information that becomes available at one level is then also available at the other level. I am sure that working out a way of taking that forward is an important aspect of this.

The other point is in relation to paragraph 46. It is this topic of professionalism, which is coming up more and more at the moment. It has also been affecting Standards. We have been engaged with the Royal College of Physicians and others in looking at exactly what this might mean in our redrafting of Good Medical Practice.

Paragraph 46 refers to the need to teach and assess professionalism. Again, it would be very useful – possibly in conjunction with PMETB – for us to take a look at this and to see if we can describe the behaviours of professionalism, and then work towards how those can properly be taught and assessed.

THE PRESIDENT: In a sense that follows the way in which we have looked at Good Medical Practice, where it has been a building-block effect leading to an overarching policy. I am slightly worried about using the term “professionalism” without defining what it actually means, which is perhaps one of the weakness of the Royal College of Physicians’ report.

DR JOHN JENKINS: I absolutely agree with that. I used the term “behaviours of professionalism”. Internationally, and indeed within the UK, I know that work has been done to start to define what those behaviours could be considered to be. I think that it needs to be taken beyond the use of a term which means all things to all people; but I think that we can and should take a lead in the development of this.

DR MALCOLM LEWIS: It was interesting in the tracking survey that the profession and the
public had very little interest, when seeing a doctor, in their fitness to practise issues as students. That is just by way of background.

If we are going to go down the route of having a student register, it ought not to be just to decide who comes off it; it ought also to be to have more input into who comes on to it at entry into medical school. It seems from some of the responses that the medical students are very keen on not giving up any of that aspect of the work, but very happy to hand over the deep end – as Peter says – the rather dirty work of dealing with people who have huge difficulty.

Also, if we are to be looking at panels, we would still need to rely on these being robust systems within medical schools – all fitness to practise processes – such that we only get those “deep-end” referrals. I am not quite sure that that is there at the moment. There is a risk here of having a much higher referral rate, if we are not very careful about first setting up the infrastructure to deal with it locally.

THE PRESIDENT: Sucking in additional, unnecessary business is a risk here unless we play this carefully.

Peter can correct me on the entry arrangements, but I think that it is technically beyond our statutory authority, although I do think that we can be hugely influential and play a real role in that, even if it is slightly beyond our technical remit.

PROFESSOR PETER RUBIN: It is beyond our technical remit and we are hugely influential. We get a lot of requests for guidance, as to whether a particular applicant should be admitted. However, it is all informal guidance that we give; it does not have the power of law behind it.

THE PRESIDENT: I get quite a number of requests from pupils at school regarding admission to medical school. Without reading them very assiduously, I usually pass them on to the relevant medical school. I had a reply back from an unnamed medical school a couple of weeks ago which said, “Dear Graeme, you must realise that you cannot apply directly to medical school in this country. You need to go through an organisation like UCAS”, and they sent me the appropriate forms!

I wrote back and said, “I appreciate that you must find this hard to believe, but I do have a primary medical qualification, and I am really flattered to think that you consider that I might be eligible for admission to medical school now”!

DR ROB SLACK: In any fitness to practise business involving students it has to be quick, because the students going through their educational processes cannot afford to wait – even some months, very often. Otherwise, it will be a disaster for them, educationally and financially.

Whatever we do, I think that bringing anything back here, whether it is registration or procedures, would very much interfere with the speed of dealing with them. I would urge us to do what we are doing in other parts of fitness to practise: keep it locally as much as we possibly can, and not bring it here at all if possible.

THE PRESIDENT: As you know, I have been a medical school dean for some time. When you try to get rid of an undergraduate, for whatever reason – particularly if it is a non-
academic reason – then they fight very strongly to prevent that happening. Inevitably there are delays at an undergraduate level, pretty much as there are at postgraduate levels as well – once you get to that stage of the procedure.

The secret is to try to avoid that if you possibly can, but not by letting people through who should otherwise not be let through, because they are a danger.

DR SATI ARIYANAYAGAM: I have some difficulty in reconciling the argument put forward by the proponents of the suggestion that things should be passed on to the GMC when it comes to a certain level of behaviour, or whatever. If I have understood Peter right, he was trying to make a distinction between the stupid behaviour of a student as opposed to dangerous behaviour.

My difficulty is that if a university of some standing is unable to comprehend that difference and is unable to act on it, I wonder whether the GMC will have the framework and expertise to do that, given that student behaviour can be very different from that of a professional.

VERY REVD GRAHAM FORBES: I am a great believer in creating lots of jobs for lawyers! There is the ever-expanding fitness to practise budget, et cetera. I think that it would be daft if we were to go down this route. However, we do have to ensure that there is a body of consistent knowledge and opinion, perhaps radiating from this office, so that the odd dean who comes across the odd student – a dean who has no real background or feel for what should be happening – can at least come here.

It is this informal network that we have advanced. We do not need more people requiring licences – or provisional licences.

THE PRESIDENT: Yes, or even student licences.

MR STEPHEN BREARLEY: I wonder if we could flag up – and I am sure that the Education Committee is aware of it – one of the newer principles that nowadays guides us: the notion of regulatory risk. Peter mentioned that the proportion of students graduating about whom there is concern is extremely small. I quickly calculated it at 0.3 per cent. So the risk is not especially high.

Then, if they do come up with any proposals for change, I am sure that they will also carry out a regulatory impact assessment in order to assess whether this will be beneficial or detrimental to the way in which this Council and the medical education system works.

MR FINLAY SCOTT: I would like to place on record how immensely proud I am of Stephen that he managed to utter those terms with a straight face!

THE PRESIDENT: And in such a restrained way. I thought that the message was fairly clear, however. “Mr” Rubin, would you like to respond?

PROFESSOR PETER RUBIN: I should assure Council members that these issues have
been raised and will be taken forward in the in-depth work we are doing over the coming months.

I am hoping that the joint GMC-CHMS committee can come up with sufficiently robust guidance, of the sort Sati referred to – “This is stupidity”, “This is dangerous” and “This is what you do with these different examples” – that we may be able to progress in a pragmatic way, with guidelines rather than with legislation.

My personal view is that if, and only if, the guidelines that we will be coming up with over the next few months failed would we then seriously be looking at the possibility of the GMC registering medical students. I think that it would be likely to be a two-step process.

THE PRESIDENT: Do you want to pick up the specific point that John Jenkins made earlier about the perceived problems in transferring information across the divide?

PROFESSOR PETER RUBIN: One of the arguments put forward by those who would like to see us register medical students is that there would then be a single body that can track individuals.

At the moment, the universities interpret the Data Protection Act and certain aspects of the European Convention on Human Rights as meaning that they cannot pass on to anybody outside that university any information about an individual student without the consent of the student. I have written to the Information Commissioner very specifically, very unambiguously, asking whether the protection of the public overrides the rights of the individual in these circumstances. I am awaiting the reply with interest.

That may also help to move things along here. Maybe the time is ripe on this one, given all that is going on in the nation at the moment on these sorts of issues – the rights of the individual against the rights of the state. It has been an interesting and hugely important area and one which we will be taking forward, with all the points that you have raised, and we will obviously be bringing it back to Council at the end of the next consultation.

THE PRESIDENT: Thank you very much, Peter. Would you like to continue?

PROFESSOR PETER RUBIN: The third area is Tomorrow’s Doctors. Since the GMC first issued guidance on the medical curriculum back in the 1880s, the pendulum has swung between us being very detailed and prescriptive through to where we are now, which is kind of a high-level. One of the things that we are looking at with Tomorrow’s Doctors is whether we have got it about right or whether there needs to be a change in the balance of the contents.

Bear in mind that Tomorrow’s Doctors was radically reviewed only three years ago. The major finding from our consultation on Tomorrow’s Doctors suggested that we had got it about right. If I can encapsulate it, that was the overall view. However, there were two aspects of the response that we are taking forward again and taking very seriously.

Very interestingly, whereas we think that over the last 15 years there has been a huge sea change in the undergraduate curriculum – with a huge amount of emphasis on the professionalism aspects, communication skills, and so forth – you might infer from the tracking survey that we needed to put even more emphasis on communication, and so on. However, a response we had quite widely, particularly from practising doctors at the frontline, was “You’ve gone too far in this direction. We need to pull back and produce doctors who
know something”.

Clearly, I am exaggerating, but I think that we need to investigate that further; find out where people are coming from; and manage that tension. What I am very keen to do is, at postgraduate level, to build on what I think is a very good platform provided by the undergraduate curriculum in the whole professionalism area. We need to look at this. We need to try to find out why the tracking survey found what it did, and find out why a lot of practising doctors feel that we have gone too far in the professionalism direction.

Linked to that, there have been concerns about specific areas which appear to have been inadvertently overlooked in the undergraduate curriculum; notably, clinical pharmacology and microbiology. Last August, for example, Audit Scotland published a report that was explicitly critical of the undergraduate curriculum with respect to clinical pharmacology.

In quite some detail, they said that the integration of the medical curriculum – which our predecessors led, of course, in the early 1990s – has led to a number of subjects being integrated out. We took this sufficiently seriously that we went up to Edinburgh and met the authors of the report, who unfortunately were not able to give me the evidence on which it was based. What happened was that when they went round to hospitals in Scotland, the chief executives, medical directors and others told them this. They were told this often enough – that new doctors did not know how to prescribe drugs and did not know about antibiotics – that they thought that it must be true, and therefore it appeared in their report.

I am taking this sufficiently seriously that we are looking at this, and looking at whether the pendulum needs to come back a bit, away from the fairly high level we are now, to start saying, “You must teach and explicitly examine in certain areas”. That is where the thrust of the review of Tomorrow’s Doctors will be coming over the coming months. Again, clearly this will be brought back to you.

THE PRESIDENT: It is one of these interesting questions that is often asked when the new PRHOs start, “Do you feel sufficiently confident in…?”. Of course, any sensible medical student or young PRHO is bound to say, “No”. Therefore, it can be interpreted as their not being sufficient. So I think that it would be very useful to get objective data on some of these issues.

DR JOHN JENKINS: I have a comment on the paragraphs at the top of page 15, which are about preparing medical students for change. One of the things that has changed most dramatically in recent years for junior doctors, particularly PRHOs, is the introduction of shift working. My conversations with colleagues in other medical schools and with junior doctors are that, at the moment, they are not adequately prepared for this. There are issues of fatigue management and how to organise your time, when you suddenly change from being a medical student and start working shifts the next day, and have to do that for one, two or three years.

It may be that some medical schools are doing this extremely well, but I am aware that it is not universal. It is a relatively new issue and something which we perhaps need to consider.

PROFESSOR PETER RUBIN: I agree. Some are doing it well and some are doing it less well. This is something where I think we need to link with NHS employers, to make sure that every new doctor is prepared for what awaits them – in practical terms.

We probably are producing people with the right knowledge and skills for day one, but there are other issues about the reality of being a new doctor on which, even though we have introduced PRHO shadowing and so on, we probably need to go further – and we need to go further with NHS employers.
In terms of what Council is being asked to do, in Annex B Paula has done a very excellent report on the outcome of the consultation. We would like to make this public, put it on the website, because a lot of people are interested in the outcome. I am looking for Council’s approval to do just that.

THE PRESIDENT: The recommendation is to endorse the intention to publish – which we have not discussed at all!

If colleagues have concerns about agreeing that now without discussion, we can discuss it after lunch. If people have read it and are content, we can agree it now. I am in your hands. Can we agree it now? [Agreed]

4b. Draft outcomes and standards for the Foundation Programme

PROFESSOR PETER RUBIN: The Foundation Programme is a two-year period of general training that follows on from graduation, and it is new. The first intake to the Foundation Programme was in August of last year.

The first year of the Foundation Programme is what was previously the pre-registration house officer year, and F2 is new. From the Foundation Programme, doctors will go on to specialty training or GP training.

F1 is enshrined in law. It is part of the Medical Act. Specialty training and GP training are enshrined in law as part of the order that established PMETB. F2 is not enshrined in law at all. That raised the issue of who is actually responsible for F2. The Education Committee took counsel’s opinion on this. It was a very lucid opinion, which gave us the option of going whichever way we wanted to go really.

With F1 there is obviously no question but that it is the GMC that is responsible. With F2 you can make a respectable argument for either the GMC or the PMETB being responsible. We took a pragmatic view that the PMETB will be responsible for F2. The Education Committee took counsel’s opinion on this. It was a very lucid opinion, which gave us the option of going whichever way we wanted to go really.

What we are asking Council to endorse this afternoon are two aspects of the Foundation Programme. First, the outcomes of the programme, which are described in Annex A. These describe the draft outcomes for Foundation Year 1 and Foundation Year 2.

Those for Foundation Year 1 you have actually seen before. Many of you will recall that we carried out an extensive review of the pre-registration house officer year and there was, as a consequence of that, a move from an experiential process to an outcomes-based process. Council expressed, I think in 2003 or 2004, a view on the proposal at that stage. One of the recommendations made by Council at that stage was that the outcomes that we had indicated in our proposals for F1 were too detailed.

What we have now done is to pull back from the detail that we saw then, to have higher-level outcomes, with all of the detail now being in the curriculum. The curriculum has been worked up by the Foundation Committee of the Academy of Medical Royal Colleges. A huge amount of work has gone on between the Academy and the Education Section, mapping over our requirements for the GMC for the detailed outcomes of F1 into the curriculum. All that has gone on behind the scenes, therefore.
What we are asking Council to do is to note and endorse our taking forward in draft form the outcomes for the Foundation Programme, to consult a little further on them, to test them and, ultimately, to bring them into force.

**THE PRESIDENT:** Would you like us to concentrate predominantly on Annex A to begin with?

**PROFESSOR PETER RUBIN:** Annex A to begin with, and I will mention Annex B when we have covered Annex A.

**THE PRESIDENT:** Are there comments from colleagues, either on the general principles involved here or the specifics? It is not nearly as detailed as it previously was but it is still quite a detailed paper, covering the seven major headings.

**DR RACHEL ANGUS:** Although I appreciate that we have seen this before and I do dimly recognise it, I have just made one point to myself regarding A1. Between bullet point 3e and 3f, which are "Establishing a differential diagnosis" and "Understanding treatment options…", surely there is "establishing a diagnosis"? I think that is missing.

You may have decided that before, in which case I stand back; but I think that this is so important that I wanted to make the point now.

**PROFESSOR PETER RUBIN:** I do not think that any of us would go to the wall on that change of wording. I think that probably can be done.

**DR RACHEL ANGUS:** I am adding a point between 3e and 3f, which is “Establishing a diagnosis”.

**THE PRESIDENT:** I think that Peter is agreeing that having a diagnosis is quite useful from time to time!

**PROFESSOR SIR ALAN CRAFT:** It is not always possible. If you are going to put another line in, it must be, “Establishing a firm diagnosis where possible”.

**PROFESSOR PETER RUBIN:** We went around in some circles on this one. Because a number of us live in the real world, and know that often you do not come to a diagnosis but you come to the possibility of a diagnosis, that is why the wording is the way it is. It was trying to reflect the reality that you often come up with a range of possible diagnoses, hence the differential diagnosis.

I take Rachel’s point that the aim is to come to a diagnosis. Perhaps, if could take this away
and come up with a form of words which reflects both the concern that you are hoping to make a diagnosis and the reality, then we will do that.

PROFESSOR CHRIS BULSTRODE: Can I make this a more general point, which I am sure Peter is well aware of? It will be astoundingly difficult to implement the checks to the assessments – valid assessments – to make sure that this is done. There is a danger that this will slip back to the situation, “If nothing is proven that they have done wrong, then they did right”. That may not be enough.

In the current environment and with service pressures upon them, the pressure on training consultants will be very high. The GMC has to be aware of that, and you may want to put something in place to try to measure from an early stage to what extent this is actually taking place – so that this is not a document coming out of the GMC that expresses hopes but not the practicalities of what is actually happening.

THE PRESIDENT: Perhaps I could put my spin on that. It would be wonderful, would it not, if we could get detailed data on this, which might make the need for a national assessment exam unnecessary at this stage? I realise that is not likely to happen, but there must be a balance here between the outcomes that you are identifying here, how they will be assessed, and how we take these young people forward.

PROFESSOR PETER RUBIN: There is a huge amount of work going on in this, because we realise that we need to assess these doctors in a meaningful way.

The Foundation Group and Modernising Medical Careers (MMC) are therefore working very closely together to come up with a practical way forward.

THE PRESIDENT: I would emphasise the point that Ed made before lunch. It has always been the view of the GMC that that should be based in practice on what doctors do, as well as what they are capable of doing in terms of an EMQ or an MCQ or whatever.

Are we content with Annex A? [Agreed]

PROFESSOR PETER RUBIN: The last bit of the Education part of the agenda is Annex B, which are draft standards for training for the Foundation Programme. These again have been discussed at the joint PMETB-GMC Group. I hope that Council will agree that they helpfully spell out what trainees can expect and what trainers know will be expected of them so far as the Foundation Programme is concerned.

THE PRESIDENT: Are there any comments on Annex B? [No response]

PROFESSOR PETER RUBIN: We are therefore asking Council to endorse our intention to share these and subsequently to provide feedback.

Can I end by saying how very grateful I am to the excellent work done by the Education Section, as ever?
THE PRESIDENT: Thank you very much. We joke a little bit about the fact that you wear two hats – GMC and PMETB. It is hugely helpful that there is decent integration between the two organisations. The last thing any of these young doctors in training need is to see some kind of loophole, some schism between the two organisations. As far as they are concerned, this needs to be absolutely seamless. Achieving that is not always easy, and I am very grateful to you and your colleagues for doing it.

PROFESSOR PETER RUBIN: It is not easy, but it is working very well. We agree with you that, from the point of view of the trainee, it should not matter at all whether it is GMC, PMETB, both, or whatever. There was an inspection last week in the north east of Scotland – an area that you have a passing interest in! – which went really well, with the GMC and PMETB working very well as a team. So I think that things are going in very much the right direction.

THE PRESIDENT: Easy, of course, in the north east of Scotland. It would be more difficult elsewhere, I imagine!
4a. Fitness to Practise statistics 2005

MR NEIL MARSHALL: The purpose of the paper is to fulfil Council’s statutory obligation to publish annual statistics on fitness to practise activity. Also, we wanted your endorsement for plans for further research into some of the issues that are highlighted by these statistics, and in particular by the report from the York Health Economics Consortium. They are issues that have been around for some years, but they are thrown into relief by this current report.

Thirdly, we wanted to get your agreement to what I hope will be a fairly uncontentious proposal: that we ask FPC to oversee a review of the annual statistics. It might be said that these statistics are too detailed and that we could perhaps bring out some of the key messages for Council in a more succinct manner, if we put our mind to it.

We are also interested in exactly what Council wants to see presented. If there is anything we could provide from the fitness to practise point of view that is not in these statistics, which you would want to see, in future years we would obviously want to provide that.

Perhaps I could pick up one or two issues from the statistics. You will see that there is again an increase in the amount of inquiries, complaints and referrals that Council receive. It is up this time to 4,980 over the year. Despite that, you will see at C5 that the overall open caseload is thankfully on a downward trajectory, probably reflecting the fact that we are becoming more efficient at dealing with these complaints as they come in, are getting things through the process more quickly, so that we have less “fat” in the system, as it were.

Regarding the conclusions from York, York did what they themselves have described as a very limited toe in the water in terms of potential research and potential statistical analysis for us. In part, that is due to the novelty of the new fitness to practise procedures introduced in November 2004. Clearly we wanted to concentrate on outcomes in those procedures. It is the case, of course, that, as at the end of 2005, we did not have a very mature caseload – in terms, for example, of cases being heard at panels under the procedures. We still had a fairly immature caseload at that time. We therefore asked York to concentrate on the front end of the process, to see what they could find there.

York have drawn four conclusions as a result of that analysis. It is Annex B at B16. It is well worth looking at those in more detail. First of all, and possibly lease controversially, they discovered that the majority of complaints – around 70% -- were about doctors who had had 20 years or more in practice, which in itself is interesting. The other three conclusions relate to a question that has been around since Isobel Allen’s report in the late 1990s and in 2000 – about a potential discrepancy in what happens to international medical graduates within our process.

First, York found that that phenomenon remains within the procedures at the moment. The telling figure on page B10 is that doctors who are international medical graduates who are complained about have a 10% chance – if you want to put it that way – of being referred for adjudication, compared to a 5% chance for UK qualifiers.

We asked York to look in particular at whether there may be some explanation in the nature of the source of particular groups of complaints. As one of their conclusions states, some of that discrepancy is explained by the fact that a greater proportion of complaints against international medical graduates are from persons acting in a public capacity – which would be mainly NHS managers or police forces.
What York also found – and this is one of the more interesting conclusions – was that the work that Isobel Allen did was based on the idea that we could use as a proxy for ethnicity the place of qualification of the doctor. I think that Isobel Allen herself had said that that was “reasonably unreliable but the best we could do”. In fact, York have found that. Now that we do have ethnicity data on some doctors on the register, they could take that subset of doctors and look at what we could tell in terms of the match between ethnicity and place of qualification. You can see at B7 that, when you look at UK qualifiers, of those where we know the ethnicity and who were subject to a complaint, 32% were not white. That begins to tell you that the use of this proxy is now increasingly unreliable, almost to the point of uselessness.

What we need to do to research those conclusions further is to take forward the programme of research that is set out at paragraph 19 in the covering paper. One of the recommendations is to ask Council to endorse that programme. The other recommendation, as already discussed, is to ask Council to agree that FPC review the format of the annual statistics, so that we can provide you with something that is absolutely as you would wish next year.

I am more than happy to take any questions on the statistics. Before I do that, Rob, as he mentioned earlier, sent an email raising a particular question. The question was about a phenomenon that seems to manifest itself in tables A7 to A12 about Health and Performance assessments. Rob’s question essentially was this. How was it that so many assessments had been completed, but without yet having a case examiner decision as to whether to refer the doctor for adjudication? I think that it would not be misrepresenting it to say that Rob’s previous experience in Performance had been that, as soon as an assessment had been carried out, we were very quick to make a decision on the back of that. The question was why, in 30% of cases of Health assessment and more than 50% of Performance assessment, we were still waiting for a final decision.

The answer is twofold. First, in the new architecture, Performance assessment and Health assessment come earlier than they did in the old process. It is part of a wider investigation, which may be into several aspects of the doctor’s practice. It is possible therefore that assessments will be completed and that will be the first evidence in, or part of the first tranche of evidence in and, before we make a case examiner decision, there are other elements of the case that need to be completed. It is not as if we are any longer running a straight-line process: assess; take the report; make a decision. There is that complexity around the investigation stage, which means sometimes the decision is not immediately after the assessment.

The other thing is that I have to confess that the statistics are not as clear as they might be on this. What these tables actually show is the cases where an assessment stage was completed. We have stated it as an assessment being completed. In fact, that is not necessarily true. The cases that are included in this, where an assessment has not been completed and a report not delivered, is where the doctor is refusing to comply with assessment. They will come out and then they will go off for further investigation down the track, before getting a case examiner decision. So an apology on that one – it could have been clearer that those kinds of cases were included in this as well. Hopefully that answers Rob’s question.

MR ROB SLACK: Yes. I could not believe that there would be as serious a problem as was apparent there. I would certainly take your reassurance that the process is working to a standard which is appropriate. I cannot get any more information from the statistics, and I do not want to enquire any further. I take your reassurance.

THE PRESIDENT: It seems to me that some of the issues that this paper flags up were discussed this morning, when we were looking at further research and how we bring these things together and, critically, about how we get further information on doctors’ ethnicity. That
must, I think, relate back to that question of whether we can get some further progress on the licence, and therefore further information on our registrants.

I think that it is that lack of information that bedevils this whole topic at the present time. It does mean that the York data, although different, and our processes are different – huge reforms to the fitness to practise processes since November 2004 – are somewhat reminiscent of the work that we did in the 1990s. It is important. I think that we move on from that. We have already identified this issue. We need to find out why it is and how we can tackle it.

**DR KRISHNA KORLIPARA:** It is an important presentation. Nothing comes as a surprise to me in what has been presented, but it strikes me as a matter of communication and sensitivity in the way we handle this, both in our communication internally as well as externally.

I had already been approached by a member of the press as to whether I can account for it. Fortunately, being long in the tooth, as it were, I have said that a disproportionate number of complaints come from the public bodies and we really have no alternative but to pursue the complaint until the evidence is tested.

However, there is another dimension to it. That is, when overseas-qualified doctors come to the UK they are not necessarily aware of the cultural norms. When things go wrong, as may happen with anyone, they often think that it is an admission of failure such that they are displaying their own inadequacy. I think that we could overcome that by addressing it when people come to the UK, by giving them some degree of training as to what the norms are here; that it is not a failure to admit when things go wrong, but in fact it enhances and is to the credit of the individual for them to hold up their hands and say, “This is what has happened. I am really sorry. We can move on from here, and I have learnt my lesson”.

If we could get the message across that there are a number of factors – first, regarding the complaints from the public bodies and, second, the overseas doctors’ reluctance to admit, for fear of displaying their failure and inadequacy – I think that we would have gone some way towards giving out the message that we are sensitive, but there are problems which overseas doctors can also help in tackling.

**PROFESSOR CHRIS BULSTRODE:** Regarding the issue of ethnicity, I quite understand that not only must we not be prejudiced but we must be seen not to be prejudiced, and we must do everything we can to avoid that. However, I am a little nervous that we do not become over-preoccupied with ethnicity and that we do much broader research, to try to understand where doctors come from who do end up in trouble.

That can feed back into all sorts of places. First, it can feed back into education. Perhaps we are not training them properly, or maybe there are cultural issues that need to be dealt with. It can also feed back into any mechanism that we might choose to adopt in the future, to try and focus our attentions for assessment and revalidation on those doctors who might be at high risk.

There is an enormous gain to be made from this research, and we should be doing a lot of research in this area; but we should not get too bogged down with just ethnicity as one of the politically correct issues.

**THE PRESIDENT:** Yes, but we do need to address it head-on, I think. We cannot keep on ducking round this one.

**DR EDWIN BORMAN:** Indeed, it is specifically on that point that I argued at the last Council meeting that we did need – government decision or no government decision – to start to collect the necessary data for licensing, as a mechanism of collecting precisely the sort of
dataset that Chris and others have argued for. And, yes, I would want that to be as broad as possible, rather than to narrow it only to issues that, to date, have drawn attention. There may well be other issues. For example, it is fairly well known that, being male – and, I believe, north of the border, or is it south of the border? – you are more likely to run into difficulties with the GMC. It is issues like that that we need to explore.

I would regard that as one of the significant innovations that the GMC should be seen to be addressing, and I regard it as a failure of the NHS collectively that we do not have that sort of data.

The second component of it would be prospective research, looking at the new procedures: how they have been embedded, and the impact that they are having. That could feed into further research on the risk-based model that we have spoken about previously.

I would like to focus on one particular area, however, namely the over-representation of overseas-qualified doctors in terms of referral from persons acting in a public capacity. There are a number of potential reasons for this – and I would emphasise “potential” – because neither we nor any other organisation that I am aware of is in a position to say why that is occurring.

One is that – and it is a very worrying one – if these are NHS organisations that are predominantly referring, there may well be some form of institutional – you cannot call it “racism”, because of the fact that I am a white African and hence overseas-qualified – but some form of institutional over-representation of overseas-qualified doctors, and what does that mean? That is one potential explanation.

The second one is that these are actually being screened out for us, and the reason that this is an over-representation all the way through is that these doctors are presenting within their places of work with significant problems. The GMC recognises that they are more serious cases, and they come through all areas of our system and are over-represented accordingly. We will only be able to pick that up with prospective data.

The third one – the one that I think Krishna alludes to and one we do need to consider and take seriously – is that it may well be that these doctors, for personal reasons and by virtue of their foreign status (and I would also look to myself personally in this capacity), may run into difficulties in terms of their practice within the UK, and that being a foreigner here in the UK itself is a risk factor. All of this is sufficiently worrying for us, as the Council, to commission necessary research in order to find out precisely what is going on there.

There is one thing that has not had attention drawn to it, other than by York themselves, but the various medical magazines have written about it to quite a large degree, and Peter Rubin referred to it yesterday. It seems to be that the last generation of doctors will always say that the next generation of doctors are not as good as they were.

The current figures do not seem to bear that out, in terms of our data; but it may well be that we need to look at why that is occurring. Is the last generation of doctors not able to deal with the changing nature of medical practice, hence they are being referred in? I feel that further research needs to be considered also in that regard.

THE PRESIDENT: Some of these trends go well beyond the UK, I think. Canada has found very similar arrangements, with old doctors ending up in slightly more difficult situations.

DR ALEX FREEMAN: I agree with what has been said about looking at the diversity issues properly. For example, why is it that women are under-represented in the GMC’s procedures? I would like to think that it is because we are all nice and cuddly, wonderful and fantastic doctors! But there may be another reason for that.

I like the way in which the data has been presented. I have a couple of questions, however.
Why has “Europe/Non-EEA” been singled out as a category, when the numbers involved seem to be rather small?

In terms of the category of new cases, I notice that we are still dividing them up into the four areas of conduct, conviction, health and performance. I cannot find anywhere where it is multifactorial. It strikes me that in a lot of these cases there are multiple factors, which is why we are now looking at fitness to practise in the round. I am thinking in particular of issues where there may be an element of health-related problem, which again comes back to diversity issues – i.e. how many of these doctors have a disability? Maybe we ought also to be looking at that kind of data. I am not clear as to why, having said we will look at doctors’ fitness to practise in the round, we do not seem to have any multifactorial cases in there.

THE PRESIDENT: I suspect that it may be a lag effect. These are the statistics for 2005. The new arrangements came in in November 2004. In a sense, therefore, most of the cases in 2005 probably did not come into the new procedures. Neil will correct me if I am wrong.

MR NEIL MARSHALL: No, that is exactly it. We are aiming at a 15-month turnaround for cases that get to a hearing. You can see that from November 2004, if we are meeting that target or are just inside that target, there will not be that many new cases, handled completely under the new procedures, which have got through by the end of 2005. That is the explanation of that particular matter.

In terms of the question about Europe, yes, the numbers are very small. It may be useful to see how that pattern builds up over time. However, we felt that it might be quite useful to separate out different populations of doctors in that way, in case it told us anything about what was manifesting itself in the fitness to practise processes.

It is possibly interesting – although we would need more research on it – that it appears that in certain cases, at certain decision points in the process, it does not matter how far overseas you are at all. The European doctors are treated in much the same proportions as international medical graduates. That might be illuminating in terms of the question of whether this is about ethnicity or some other characteristic, or whether it is something to do with having been educated and qualifying in the UK.

I think that it is therefore useful to carry on dividing it in that particular way, in case something does manifest itself that draws our attention.

DR JOAN TROWELL: Listening to the last two lots of issues relating to place of qualification and age of doctor, I am reminded that there are lots of ways of getting on to our register – before we necessarily jump to the conclusion that it is older doctors who are bad. Training has changed in that time. In particular, if we are looking at overseas-qualified doctors, some of the people who qualified overseas but have been on our register for a long time will, for example, not have taken the PLAB test.

I think that part of the motivation of looking at EU and non-EU – and I am looking at Amanda to put me right if I am wrong – is that the non-EU Europeans still have to take the PLAB test, whereas the EU ones do not.

There are therefore different reasons, different backgrounds and different ways of getting on to the register. We have to remember that in looking at some of this information – and, historically, it has changed.

THE PRESIDENT: The recommendations are somewhat bland, but are we content to move on to them? Recommendation 2a is simply to agree that the format should be decided by Fitness to Practise and should meet the needs of Fitness to Practise and this Council. It hardly seems contentious. Are we content? [Agreed]
The second recommendation is that we need to do further work to find out why we have got the figures which we have got – which again seems to me pretty much a good idea, if we could only do it. Are we content? [Agreed]
6. Engagement: patient and public involvement

MS SOPHIA BHATTI: The paper on item 6 reviews our patient and public involvement work to date and also sets out an action plan for the remainder of 2006. You will see that some of those activities span into 2007. However, essentially our engagement work is embedded in our commitment to be a responsible regulator. Much of this has been picked up in the governance review and, within that, the emphasis placed on the need to engage with our key stakeholders. This paper looks in particular at patients and members of the public. I understand that in September we will be bringing a further paper that will look specifically at our engagement with the profession.

In March 2005, Council will recall that we set out our direction of travel in a document entitled Working towards a Patient and Public Involvement Strategy. It set in place a fairly innovative and experimental approach to our engagement with members of the public and patients, to see what mechanisms would work; with whom they would work; how they might impact upon our policy.

The paper sets out a few of these examples, some of which are very new to the sector of healthcare regulation, and one or two of them with which many members will be familiar. There was the Good Medical Practice review process, involving public seminars and meetings, which were innovative and very different for the area in which we operate. There was also a “Citizens’ Jury”, which allowed a deliberative and informed discussion with members of the public on a fairly complex area of policy. Those who were at the Council dinner last night will have heard reference to “refined public opinion”. This is not so dissimilar from attempting to get that level of engagement with members of the public.

The sum total of our activities – and I hope that Council will agree with this – is that we have made a considerable amount of progress over the last 18 months. We have undertaken a host of activities which have really impacted upon our policy. Those people who are undertaking policy have found it very valuable. That is not to say that we do not feel that we could do more or that there is not room for further improvement.

To set that further development work in train, we propose to frame our ongoing activity along the lines of key principles. Those principles are outlined in the paper before you.

The four key principles are based on pre-existing good practice. The first is to engage at as early a point as is appropriate and possible, the theory being that the greatest benefit is often derived from engaging with key stakeholders – and this would equally apply if we were engaging with the profession, I am sure – at as early a stage as we can, to ensure that our policy is appropriately designed.

The second principle is one which Council has touched on previously in discussions on public and patient involvement, namely the need to differentiate between the input we derive from working with representative organisations – which is very valuable and has a very clear place in our engagement work – but being able to differentiate that from the engagement we may undertake with individuals who are not “networked” in any way. Those opinions may well be different simply because individuals are not “networked” and do not have the background knowledge of the way in which regulation operates. It may be important for us to be informed by their perspective.

The third principle is to focus upon the seldom-heard groups, sometimes referred to as “hard
We are not wedded to either of those terms, but they are fairly clear. We have undertaken a considerable amount of work in the last 18 months, but we have also identified that it has often been very difficult to focus on and obtain the input of certain groups within society. Nonetheless, it is very important to gain input from them, and so one of the guiding principles is that we should actively seek out those views. That may require building it into project plans earlier, and perhaps dedicating a particular resource to that. Those groups will differ, depending upon the policy in hand. For example, if a particular issue impacts upon those of an older age, then it is likely that the seldom-heard groups there will be different to those in relation to other policy issues.

The final principle set out in the paper is that the development of policy ought to be open and transparent. The two key principles within that are that we ought to seek opportunities to be as open as we possibly can be in our policy development but also that, when we make that information available, we make it available in an accessible format. A distinction is sometimes made between information and knowledge. Information is just information on a page, but it does not translate into knowledge unless it is understood.

Those are the four key principles which we propose should set the framework for our future engagement work, and lead to our first recommendation.

PROFESSOR IAN HUGHES: In terms of the principles, referring to 18(c) where we are talking about the hard-to-reach groups, I note that, again, people with mental illness or disabilities and their carers are not mentioned specifically, though lots of others are. I wondered if we could have a specific inclusion of those groups of people. They are particularly hard to reach; they are often ignored. I think that it would be helpful if they could be added into that list, so that specific reference was made to those particular groups.

PROFESSOR CHRIS BULSTRODE: One of the other principles we have dealt with in terms of consultation with the medical students is that, not only should we consult them, we should also feed back to them what we have done with the consultation and show them that they have been heard and that we have taken action.

THE PRESIDENT: I think that loop is quite important, is it not? Even if you decided at the end of the day not to do anything, feeding back and explaining why not is useful.

MR ALAN HARTLEY: I have been involved in one way or other in PPI for about 12 or 13 groups, and hard-to-reach groups really are hard to reach. I take the point about feeding back, which is something I have always tried to do. But please do not underestimate how difficult this is.

Usually, the only time you can involve or get positive input from hard-to-reach groups is when they have something that they want changed. It is a matter of trying to keep an eye on the ball, so that you try to find an issue that is causing concern and then you will get them involved.

I do take the point about feeding back, however. I have always said that in my years of involvement with CHCs, when a trust held a public meeting. “Give them the truth and feed back that we haven’t done this because….” or “We have done this because….” – but please do not underestimate the difficulty of these hard-to-reach groups.

THE PRESIDENT: I am sure that we do not. I should have checked with you before, but I take it that you yourself are content with the contents of this paper, are you?

MR ALAN HARTLEY: I am content with it, yes. There is just one query that I have raised
with Sophia but, unless it comes up in discussion, it has been answered to my satisfaction.

**THE PRESIDENT:** It looks as though we are agreed on the principles then. Can we move on to the action plan? I will come back to the recommendations formally at the end.

**MS SOPHIA BHATTI:** Building upon the principles that we have just discussed, the proposal is that we take forward our annual activities on a year-to-year basis, to be co-ordinated with our annual business planning cycle. As we identify our objectives, therefore, we also look at the opportunities for patient involvement – as we might do with any other stakeholders, and as we might also look at resources.

In terms of 2006, we are midway through the year and so we have appended at Annex A an action plan for the remainder of 2006. It highlights some key initiatives we want to continue with and fulfil during 2006.

The paper highlights a few of these. Some of them may be familiar to members who are involved in particular committees, so I will run through them swiftly. The first of them is the Readers’ Panel, which is currently being commissioned. We have put out a recruitment call. There is a small error in the paper. We are not sure of the exact figure there, but suffice it to say that it is in the thousands. The response has been very successful. The purpose of that Readers’ Panel is to allow us as an organisation to test and pilot-run various forms of communications, not only those that are deliberately based on information for the public in terms of leaflets, but also such things as standard letters – to ensure that our tone and content is appropriate, clear and transparent.

The second initiative we have highlighted relates to the work that Fitness to Practise are undertaking in relation to consensual disposal. The draft Section 60 Order gives us the power to impose restrictions on a doctor’s registration by consent, without the need for a fitness to practise hearing. Fitness to Practise are very keen to ensure that the implementation policy is informed by the views of patients and members of the public. A small piece of qualitative research is being commissioned at the moment, which will then feed into the formal consultation process.

The third initiative I have highlighted in the paper is an exploration of an initiative. It is the establishment of a not-for-profit bursary scheme. The rationale behind this is that we rely upon the co-operation and resources of the not-for-profit sector quite significantly in our work with patients and members of the public. They are increasingly stretched in their ability to engage with us in an appropriate and timely way in order to ensure that that input is valuable. We want to look at how we may be able to offer some form of a bursary scheme to small, not-for-profit organisations. It may be something we would want to explore in partnership with other regulators in the health and social care sector.

The final initiative highlighted is the work in relation to the specialist register review. It is a review that we committed to in 2005 to assess the fitness for purpose of the specialist register, and the review is underway. A short-life piece of research is being commissioned in relation to user needs for the specialist register. It is hoped that that will also involve members of the public and patients. That leads us to recommendation 2b, which is for Council to endorse the action plan.

**PROFESSOR IAN HUGHES:** This point probably sits between the principles and the action plan, but I think that we are missing a trick here. There have recently been set up a number of foundation trusts. One of the characteristics of foundation trusts is that they do have a large constituency of patients and public who are involved with that particular hospital. I think that we are missing an opportunity to build on the availability of communications with those groups of people in foundation trusts, to find out what those particular groups of individuals feel about things.
In a sense, it is a readymade involvement of people. Their addresses are there; their contacts are there. I am sure that there is something we could be doing to piggyback on that. I think that there is some way we could be involved with those foundation trust constituencies that might very well strengthen this – at very little extra cost or effort. It gives us a readymade platform to get involved with patients and public who are already interested in health issues and who are representative of their local communities – because that is what foundation trusts have to obtain from their communities.

THE PRESIDENT: Maybe we could have a word with Patricia Moberly, because she is the chairman of a biggish foundation trust, and perhaps see how best we can make use of that. It is a good idea.

Can we go back to the recommendations? First, recommendation 2a, to approve the principles. [Agreed] Second, to approve the action plan. [Agreed]

Then there is the third recommendation, 2c.

MS SOPHIA BHATTI: Over the course of the period to which this paper relates, which is to the end of 2008, we will undoubtedly expend a great deal of resource and energy, and we will want to ascertain whether or not that has resulted in the sorts of impacts that we are looking for. We will want to learn about how we may be able to improve, and also want to be able to applaud the good work that will have taken place in that period.

The proposal is therefore to undertake a review at the end of the period, namely the end of 2008, but as part of this to bring an independent perspective to it – which will no doubt assist in the review process to make it both objective and also to allow us to learn. That leads us to the final recommendation.

THE PRESIDENT: 2008 seems quite a long way away to me. It may be useful to keep the Council up to date with what is quite an important part of its engagement strategy. Getting these concepts right does matter. With that slight addendum, are we happy to have this situation reviewed formally at the end of 2008? [Agreed]
7b. **Consultation on the electoral scheme**

**THE PRESIDENT:** At our last meeting we discussed the need to do this now, if we are to get the organisation in gear for the election taking place early next summer. I think that we need to do this regardless of whatever may be proposed on Friday from the Donaldson report. We need to proceed as we think best at the present time, therefore, and not pay any attention to any changes that may or may not be suggested in the future.

**MRS SARAH BEDWELL:** Before we start, I want to refer to the paragraph about conflict of interest – because I have had a couple of queries about that. There is a perception of conflict of interest for those who are elected medical members in England; potentially in other places, but mainly in England.

There is case law which Finlay and one of our lawyers managed to find yesterday afternoon. It explains that – where you are the only body who can take a decision, as indeed you are – if all elected members stood aside, we would not be quorate and you could not take a decision, then you can go ahead and take that decision.

**THE PRESIDENT:** Thank goodness for that!

**MRS SARAH BEDWELL:** It was not explained in full in the paper, so we thought that you might find it helpful.

**MS SALLY HAWKINS:** I was one of the people who raised this before the meeting, because I do have a very real concern about the appearance of probity. Clearly, for this discussion, we are in the situation we are; we cannot take a decision unless all members of the Council take that decision – or at least a quorum.

However, I would like us to rethink how we run our business, so that there is an opportunity in the future, when we come up against situations like this where there is an apparent conflict of evidence, for us to suspend standing orders or to change the quorum for the purposes of that particular decision. It worries me that there is an appearance of conflict.

**MRS SARAH BEDWELL:** There is unfortunately no way in which we can suspend our quorum. I have to say that there are various times when I would like to do that – and about half-past three this afternoon is very definitely one of them! But it is in our Constitution Order, so it is within the gift of the Government. It is something we can identify as a matter to be discussed with them, should we be looking at constitutional changes. At the moment, however, your quorum is your quorum.

**MS SALLY HAWKINS:** Perhaps we could at least talk about whether that is something which we work towards in the future. That was my point.

**THE PRESIDENT:** In the interim, if there are situations where you feel uncomfortable and you feel that we are erring, perhaps you could flag them up. None of us would want to be seen to be doing that. We need to be seen to be pristine.
DR BRIAN KEIGHLEY: If we are an organisation that has, under Merrison, an elected medical majority as part of our constitution, it seems to me that the conflict of interest is inherent in our constitution. I cannot see any way out of that. I think that we have to recognise it, and to decide now that that potential conflict of interest is inherent and cannot be overcome.

THE PRESIDENT: I think that, first of all, we need to recognise it and then see how best we deal with it. If in fact we cannot do anything about the quorum, we need to recognise the potential conflict here and ensure that people face up to it.

MR FINLAY SCOTT: It may be better if we do not talk about a “conflict of interest”, because I am not sure it is a conflict of interest. I think the issue is whether there might be actual bias or a perception of bias, which is a slightly different thing.

If I may develop Brian’s point, the reality is that, every time we discuss anything to do with the medical profession, it could be argued that there is scope for actual bias or a perception of bias. We have to deal with that in a sensible way.

If I may say so, where I think Sally does have a valid point is in relation to the paper that is before you. Depending on the decision you take and its effects, it may or may not alter the chances of one or more members being elected; so there is clearly a potential link there. It seems to me that the important thing is to recognise first of all that you are not being invited to do anything improper. As Sarah has explained, it is established that, as you are the only decision-makers, you may go ahead and make the decision.

However, picking up Sally’s point, we also have to be clear that there are opportunities for members to declare what I think could then be conflicts of interest, on an individual basis, in relation to particular papers. I think that is a slightly different point. The idea that the majority of the Council would have to consider standing aside whenever there was a discussion about a medical matter would clearly not be sensible.

There is something about making it apparent that you have considered the point, which it seems to me you are now doing, before moving on to consider the paper. That said, if we could take delivery of Sally’s suggestion, the spirit of it, and do some work in terms of looking at standing orders or how we deal with situations – not normally of actual bias but the possible perception of bias – we would be very happy to do that.

THE PRESIDENT: Sally, are you happy with that?

MS SALLY HAWKINS: Yes. I just wanted to clarify that of course there are clear interests for medical members, but there is a personal financial interest in this discussion, which makes it different from the other kinds of discussions. That is why I was raising it here.

MRS SARAH BEDWELL: In our discussion in March we identified three core policy issues, and I would like to look at those in turn. There is a lot of detail in the paper which I will not go into, but I am happy to take any questions.

The first issue was public interest. This arose out of Governance Review Group discussions, and I think that Brian had an idea of a two-tier way of having people stand for elections. What we have tried to find – and we have talked to the Department of Health in England about it, and they can also see a way of doing it – is a way of trying to bring a sharper focus on the public interest and on members’ responsibility in the electoral scheme and, hence, in the literature. We are therefore planning that prospective candidates would effectively have to
declare three things, in addition to the current declarations. Those are: their intent to support the GMC’s purpose; to act in the public interest; and to follow Charity Commission guidance.

That is nothing new in terms of what you do. It is what you all have to do now. It is not a new obligation. However, it would mean that, when people are looking at the candidates’ pack, they know what it is they are getting into. Equally, anybody who is voting will see that that affirmation has been made.

THE PRESIDENT: Are there any comments? Not contentious? Do we agree it? [Agreed]

MRS SARAH BEDWELL: I suspect that this will not prove to be quite so “not contentious”, if I may put it that way!

The next thing we looked at was diversity and participation. We put those together because we feel that the proposal we have covers both of them. If we go back to the first Governance Review Group – which now seems quite a long time ago – our aims then were to have an inconclusive Council, and we were also looking at diversity. We know that Council can never been representative or reflective of the medical community or of society more widely. What we can do, however, is put an electoral system in place which supports those aims of inclusivity and diversity.

When we looked at it in 2002, we moved from what was then one English constituency to five. Our aim in doing that was to increase participation. You will probably remember the very long ballot papers from 1999 and from the by-election. Our advice at the time was that, if we did that, by increasing participation we would also get a more diverse Council. In fact, from looking at the statistics, as we did in March, we know that that was not the case; if anything, it had a negative impact. It was a very small impact, but it did reverse the trend we had had of improved diversity.

The paper explains that we think that the only thing we can now do is to move to one constituency. If we accept that having five constituencies, or smaller constituencies – whichever way you put it – does not deliver either of our aims, it is quite difficult to justify some sort of middle ground.

We accept that that will bring problems with long ballot papers and all the issues we had before, but we have struggled to say what three would give us that five does not. That is why we are recommending one constituency for England.

At the same time as doing that, we need to have a fairly full programme of engagement and participation. That would be for candidates as well. We would want to go to representative groups and various minorities for doctors, encouraging them, probably from about the autumn, to make sure that they have candidates who can stand, and also to look at some very wide publicity for the elections themselves in GMC News and the medical press.

THE PRESIDENT: There is absolutely no right and wrong to this, but there could be endless discussion on it, I fear.

DR BRIAN KEIGHLEY: Sarah has alluded to it, but I think that the biggest criticism that we faced in the 1999 election was the incredibly long and unwieldy voting paper. I do not have an interest in this because I do not stand for election in England, but I know that the profession was really quite turned off. Not only that, but many of the candidates were very turned off because, even though there was no alphabetic problem – it was done at random – the people who were at page 16 of that document felt that voter fatigue significantly disadvantaged them.

We will be bringing forward a paper soon on professional engagement and, while the aims of
diversity are very difficult to address, I wonder if we shall lose more than we gain in reverting back to something which drove us into dividing England up into constituencies last time.

One of the problems we had in 1999 was that, not only did we want people to vote, we wanted more people to participate in the election. We went out and tried to get younger doctors and different types of doctors; we encouraged people to stand. From memory, it was something of the order of 200 candidates. [Several members: 300-plus]

I just despair at the thought of the voting paper that the English voters will be faced with.

THE PRESIDENT: I have every sympathy with that. In terms of the number of doctors who actually voted, of course, it did not make very much difference one way or the other.

MR ROB SLACK: I do not have very much more to add to what Brian was saying. It was a big confusion. I am not sure that it was randomised; I think that it was alphabetical.

MR FINLAY SCOTT: It was alphabetical.

MR KEVIN BARRON: I agree with Brian. I was on the original Governance Working Group, and that ballot paper with 300-odd names on it was incoherent. I do not think that we broke it down to five in England on the basis that we were likely to get more participation. Diversity is an issue, and it was always a problem for the Council. We said that co-option was one of the ways round it, after the ballot has taken place. I think that this would be a backward step.

THE PRESIDENT: Given the new arrangements with the NHS Appointments Commission, the co-option might work better in the future than it did in the past. Just because it did not work well last time does not preclude the possibility in the future.

DR EDWIN BORMAN: I suppose that I do have to indicate that I am an elected member, and that I have followed these elections for quite some time – sad person that I am! – and have all the spreadsheets, et cetera. There are a couple of constants we can learn from.

The first is that with the two major elections in this form – GMC Council and BMA Council – when the number of candidates go up, they really do become unwieldy elections. It is related to the number of candidates standing.

I have discussed this with Sarah, and my strong advice was that, if you are looking to get an appropriate balance between what are three variables – i.e. the number of candidates likely to be standing, trying to increase the number of people who vote, and trying to get sufficient representation so that you get a diverse number of candidates elected – it would probably be best to go for three.

Sarah’s entirely correct response was, “How are you going to divide England up?” – and I left that problem with her! My own suggestion would be to divide England into three bands: a North, a Midlands, and a South. If we went back to one single constituency, I am very fearful that we will have exactly the same problem that we had the last time but one, namely that there will be many people standing. With a smaller number to be elected, it is very unlikely that we will get the benefit of having a high turnout – plus having a sufficient number of people, other than the “usual suspects”, being elected.

THE PRESIDENT: There are quite a number of people who want to speak. I just want to put it the other way round. Does anybody want to speak in favour of the one constituency?
DR PETER TERRY: I do not really want to speak in favour of the one ----

THE PRESIDENT: You just wanted to speak!

DR PETER TERRY: …but I was going to suggest that, if you do decide on one – and it was a suggestion I made at the last meeting – the statement should be reduced quite considerably, from 100 words down to perhaps 50 words, or possibly even shorter, on the basis that this Council would welcome anybody who is perhaps more concise than even myself!

MR STEPHEN BREARLEY: I am not sure I have much to say that is not already in the paper. The argument is very clearly made out in the paper for a single constituency and it seems to me to be irrefutable.

We went to five constituencies in the hope that more people would vote. More people did not vote. All that we succeeded in achieving was a less diverse Council than we have had before. It is quite clear that the five-constituency model was a failure.

It may be that people do not like having a voting book which is several pages long; it may be they have to do a bit more work; but the fact of the matter is that we are interested in the outcome. We are interested in how many people vote and what sort of mix of people get on to the Council. The argument is quite clear: that we are most likely to get the result we want by having a single constituency. You cannot refute it.

DR ROSALIND RANSON: I think that part of it was also to enable people to vote for people who they were more likely to know something about. By limiting the constituencies to five, you were more likely to be able to have an informed vote. I would keep five constituencies.

The voting paper was completely unwieldy. I cannot remember how many pages it ran to. It might have been 30 pages. There were 360 candidates. It was not widely publicised. We are going to increase participation. The proposal is to do everything that we can to increase the number of candidates, so we will end up with something far more substantial than 360.

I would encourage you to keep to the five constituencies and not change the rules on the basis of one election. It was a different election. When we had this one constituency, we were voting for 104 Council members. I cannot remember what the split was. The change was to a Council of 35, with a new electoral scheme. To say that it did not work on the basis of one election is not a good idea.

THE PRESIDENT: We were voting for 54 elected members at that time.

MR ROB SLACK: It was 42 in England.

DR ALEX FREEMAN: I am in favour of changing from the current situation, but changing it so that it is a single UK STV, with constraints, according to the four UK countries, in terms of who you actually elect.

I was first elected in 1999 on the huge, horrendous ballot paper, but I would suggest that that paper and the number of candidates standing were a response to a rather contentious decision that the Council had taken. There was therefore a huge amount of interest in the GMC at that time. As we saw from the last election, there was nowhere near that number of candidates standing. So I would suggest that the interest in getting yourself elected on to the GMC had probably dropped back to what would be an average level.

In terms of voter participation, if people can be bothered to vote in an election then they will
vote in that election. If you look at the numbers in terms of the GMC elections and other elections where they have similar constituencies, you will find that the percentage of people eligible to vote who actually vote remains pretty constant. I therefore do not think that, by changing the size of your constituencies, you will encourage or discourage people from voting. The people who care enough to vote will vote, and people who cannot be bothered to vote will not be more bothered to vote because of the fact that they have a smaller ballot paper – as we saw from the last set of elections.

My view is that we should have a single UK vote, but with the appropriate constraints on it to ensure that we do get the full UK countries represented. That is the way that you can be most diverse in terms of the people who come out in the final count, because you will have the whole UK constituency voting in an STV.

DR KRISHNA KORLIPARA: When we discussed the possibility of dividing the constituencies, we based it on the premise that England as a whole was too large a constituency and people were not voting as much as they might do if it were broken down into five separate constituencies. In fact, we know that it has not come to pass. The whole basis on which we made that division has therefore been turned on its head completely, because people have not come out to vote in the numbers that we hoped for.

I would also argue that in any democracy the key word is “choice”. Why should we not give choice to the people, rather than arrogate to ourselves the right to presume that people will be put off? Where is the evidence that they will be put off? You may have had one or two of your friends saying that they were somewhat overwhelmed by the number. However, whether it is 300 or 340, people may exercise their choice not to look at the list – but should have the choice.

May I argue it the other way round, from first-hand experience? There were a lot of people whom many voters might have considered as candidates of their choice. They have not been allowed to vote for them, because they happened to be candidates in a neighbouring constituency – and vice versa. If we agree that choice is the key word, we should consider the possibility either of having one constituency – and here I am in real danger of agreeing with Ed Borman! – or three constituencies if one is unmanageable. Please let us stand back, look at it, agree honestly that these five smaller constituencies have not worked, and let us look at the possibility of three as a compromise.

PROFESSOR SIR ALAN CRAFT: I would be in favour of a single constituency for England. I suspect that it would be difficult to have it for the whole of the UK. My understanding is that one of the big problems when we had the massive ballot paper was voter fatigue and that people who were in the latter few pages had significantly less of a chance of being elected than those in the first few pages.

Is it technically possible to have several different versions of the ballot paper? Say five or 10 different versions? With computers, they can actually mark it quite simply. People would then have a chance of being on the first page in some of the ballot papers. It is to get rid of that problem of voter fatigue. It should not be beyond the wit of a computer person.

THE PRESIDENT: I think that we did look at some of these data. It was a sort of modern myth that it was first or last and, when we looked at the data, I think that it was not confirmed. Dr Ziegler was on the Council at that time. It was not just first or last. We did sample from the different pages, and there was no statistical correlation.

MR FINLAY SCOTT: There was not much evidence to support the belief that those in the early pages stood a better chance than those in the later pages. I cannot remember where this constraint is, but currently there is a constraint that it has to be in alphabetical order. When we asked what that meant, we were told, “It means alphabetical order”!
I am very happy to take delivery of the point and go back and revisit where the word “alphabetical” appears, to see whether we could do something about that, as suggested.

One of the difficulties is the one to which Rob and others have alluded. 1999, which was the last time we had a single constituency, did require voters, if they wished, to vote for up to 42 people in England. I do not think that we should underestimate quite what a challenge that might have been. It may have been a significant contributor to the reported voter fatigue, as much as the length of the ballot paper.


MR FINLAY SCOTT: Yes, that is correct.

THE PRESIDENT: I was going to try to deal with Alex’s point first and see if we could deal with the UK-wide issue. It seems to me that, however legally possible this might be, it is not practicable at the present time, given devolution. I am not at all sure that we should, as a Council, turn our minds to that at the present time. If Council tell me that there is a huge interest in doing it, then of course we could look at it. I am just not sure, listening to other people, that there is very much interest in doing that. What I am trying to do is to cut down the options here, so that we can move the debate on. Does anybody else feel that we should be looking at this on a UK-wide basis?

PROFESSOR CHRIS BULSTRODE: I have two issues. One is that, as a Channel Islander, I declare an interest. I hear a lot of Scottish accents round here. My understanding of history is that the Scots have always been renowned for trying to divide and rule. So we should be cautious about the view that any Scotsman makes about five constituencies!

Secondly, it seems to me that the worry about the last election was the number of people who applied to be on the GMC. Perhaps a little more clarity about how much work is involved in being on the GMC and also, as Rob was saying this morning, how much you are loved in your local hospital – and how you are taken aside in a corridor almost on a daily basis and “Zidane’d” by some doctor or other for all the frustrations they have in life – might persuade one or two people that they did not really want to stand for this privileged post. As one person said to me, “Do you really want me to punish you by voting for you”?

THE PRESIDENT: I am not sure that was terribly eloquently in favour of a UK-wide constituency, but never mind! Alex, do you want to come back? There seems to be no great support for the concept.

DR ALEX FREEMAN: I think that there is a fundamental misunderstanding of what is proposed. I am proposing a single UK vote, which is perfectly possible to do. The constraint that you put on it is that you decide how many people from each of the devolved nations that you want on the Council. I would suggest that you would probably think in the region of Northern Ireland, one, Wales, one, and Scotland, two – which is what we have at the moment.

What a single UK vote does, however, is give people in all four countries of the UK the chance to have a single transferable vote on all of the candidates in the election. Therefore, it is the most likely way in which you can guarantee the widest possible diversity in the outcome of the election – which seems to be the issue here.

If you went and talked to people like Electoral Reform Ballot Services and went through the various, assorted permutations of the number and types of constraints that you can put on when you have a single-vote STV election, you would find that it is not actually as complicated as people think.
THE PRESIDENT: But there does not seem to be a great deal of enthusiasm for it at the moment – is the point I am making.

DR ALEX FREEMAN: I am a great enthusiast for the STV system, which is why I am proposing it.

DR JOHN JENKINS: I suppose that I do need to declare a potential bias here. I think that the problem of Alex’s suggestion would be how many doctors in England would know any of the doctors from Northern Ireland who might choose to put their names forward, and whether that would give any local ownership of the eventual makeup of Council.

DR BRIAN KEIGHLEY: That is largely my point as well. I am perhaps fortunate, in that I am fairly well-known in England because I am on the BMA Council and I chair the Joint Committee. That would be an inherent disadvantage to other people in Scotland who are well known in Scotland and have good reputations in Scotland, because I would probably get more votes by being known in England. That would not go for local ownership, and I think would be a mistake.

THE PRESIDENT: I think that there is no great enthusiasm for that concept. Can we look at the two main options? People have talked about three, but it seems to me that what we are talking about is whether we are going for a single constituency or are we going for five. The paper argues for the single constituency, for all the reasons that we have discussed around the table. The counter-argument was that it was unwieldy, we would have a very large ballot paper. It may be different time, because we are electing 15 people from England rather than 42. We have a smaller Council; there may be less interest in doing it. It might counteract some of those practical disadvantages.

Are we moving, however reluctantly, towards a single constituency for England?

DR EDWIN BORMAN: Given that recommendation 2d is “To delegate authority…to determine whether to proceed with consultation”, and given that there is some argument in this about the number of constituencies, I would have to say to Sarah that my personal view is that it is not sufficiently persuasive; that we do consult, but that we do so on the basis of whether there should be one constituency or three.

I would argue that the move to five constituencies was a failure. Here, I regret, I have to continue the “love-in” and agree with Krishna now! Given that we do have some opportunity to have a consultation, I would argue that it be on one or three England constituencies.

THE PRESIDENT: Finlay is whispering in my ear and saying that it would be more helpful if we could define the argument, so that we are consulting on a proposal that we change – rather than consulting just to find out what people think. We would still need to make a decision today and we could consult thereafter, but it would be very helpful to decide as a Council today what our views are, and then go out to consultation on that.

MR FINLAY SCOTT: It seems to me that, given the timescale, what the statutory scheme envisages is that we will consult about proposed changes, as distinct from consult about what changes we might make.

There is nothing to stop any form of consultation but, given that much of this will boil down to a personal judgment in the light of not very robust evidence one way or the other, it does
seem to me that it may be more helpful to those who will be consulted if we have a position from the Council – but that we also include as part of the consultation the option/options that were also considered, but not adopted, subject to the consultation.

**THE PRESIDENT**: Would you allow us to include, as I understand it, your three proposals – if that is what Council wants to do, Ed?

**DR EDWIN BORMAN**: I am a bit wary about that, President. You know and I know that consultations can bias the response. Heaven knows, that might have happened with revalidation, if memory serves me! Of course, we would not do anything like that again, would we?

I would be more concerned that, were we to go to consultation, we get the arguments pro and con on each of the options, and I would suggest that the options to consult on – and I am quite happy to take the counter to this – would be on one single, England constituency and three (however we break them up) England constituencies; that we do give the pros and cons for each of them; and we truly consult, rather than say, “This is what the GMC is putting forward, and here are the ones that we rejected”. Those that are in the “reject” pile tend to be regarded as second-rate, also-rans, and “We don’t really want your opinion on those”.

**THE PRESIDENT**: Let us hear a few more views, and then we will come to a conclusion reasonably quickly.

**MS RUTH EVANS**: I do not think that we as lay members have talked – probably because we do not have first-hand experience – about this issue, although doctors are quite keen to discuss the arrangements for the appointments of lay members. This is not a dig; it is just interesting – because we are not the constituency, as lay members.

I rather agree with Stephen’s views, which are that, on the face of it, the paper contains good reasons for going to a single constituency. However, the paper does lack the evidential base for making that assertion. It is, “The other one didn’t work”.

I wonder if, as an evidence-based regulator, what we ought to be doing is, rather than consulting, getting some evidence from the punters and doing a small-scale poll of doctors out there, in the constituency, through an agency – I do not know how you do it representatively but they do. Just a very quick poll, over the next week or two, to find out what your constituencies would find the best way of being able to elect their members from. Then we will have the evidence on which to make some decisions. On the face of it, as Stephen says, it appears to be self-evident that we ought to go for the option that would produce more diversity.

I do not know and, rather than consulting with stakeholders out there, we ought to be consulting with those who will be voting.

**MR ROB SLACK**: By when do we have to make up our minds? When is the latest?

**THE PRESIDENT**: Tell us the timescale again, Sarah?

**MRS SARAH BEDWELL**: Today, really. You need to consult over the summer. If we leave it until September, you will not have time to do consultation, to make the changes ahead of next year’s election.
**MR ROB SLACK:** So we can consult before we have to make a final decision?

**THE PRESIDENT:** We have to consult, so we need to come to a decision today as to what we are going out to consultation on. I think that is what Sarah is saying.

**MRS SARAH BEDWELL:** That is right.

**MR ROB SLACK:** I think that the appearance to the profession – which has not been quite touched on but which may have been alluded to – is also important here. The profession, from my conversations, did not like 360 people on a ballot paper. They actively did not like it. It made the GMC look foolish. Although I accept what Stephen says, and there is not a lot of evidence around, I think that it would look much better to the profession that they have a reasonable choice – if it is just a fewer number of candidates on the ballot paper.

**THE PRESIDENT:** We just want to be careful that we do not repeat history. 360 is not likely in the new set-up, I guess – because we have only 15 seats.

**PROFESSOR PETER RUBIN:** I am not a member of Council and therefore do not have the interest that others do have. A number of you have said, “It has not worked”. I think that we have to be very clear what “it” is that has not worked. The purpose of the election, surely, is to elect a Council that is competent to discharge its responsibilities? That is the purpose of the election. I am not clear what the evidence is that the Council has not been competent to discharge its responsibilities.

If “it” is that you would like the Council to reflect more closely the population of doctors in the UK with respect to ethnic minority doctors, staff grade doctors, trainees, or whatever, then that should be made clear when you consult. If “it” is that you want to change the number of people who vote from ‘n’ thousand to ‘x’ thousand, or ‘x’ thousand to much more, then that should be made clear when you consult.

I have been struck by the lack of clarity about “It has not worked”. You have to be clear what “it” is that has not worked.

**MR KEVIN BARRON:** I cannot remember how scientifically based our consultations were, but we did consult about the issue of moving away from one constituency in England. It was not just about voter participation. Far from it. What we tried to do was get a geographically representative Council, so that people out there would have some ownership of these candidates who come in front of them on a ballot paper, and that there were not national lists, headed by people who are on television every other day. That was the debate that we had at the time, both in the governance group and also in the Council.

The idea that, because we failed to increase voter participation in one election, you then want to re-draw the boundaries – we re-draw boundaries for Parliament every 10 years. It has nothing to do with voter participation; it is about the size of the electorate.

This will not do that at all. It is trying to give people a sense of ownership of their representatives on this Council. Quite frankly, I think that the idea that, after one shot, we are writing that off now and going into something different, is daft. You have no idea how many candidates we will put up. It could be 360 and it could be 3,000. You have no hold on that whatsoever.
PROFESSOR MICHAEL PRINGLE: Kevin has very eloquently made the point that I wished to make, namely that the status quo is five constituencies and one of the motives for that was the fact that we did not want disproportionate-sized constituencies. It is a way of balancing out the approximate size of constituencies.

I think that we have given it one run. It has not been a disaster. In fact, the evidence is not that we should be reforming it; I think that we should be trying it again. I think that five constituencies should be tried again, with a very close monitoring. It should be the status quo that we are going for. If that does not prove to be successful, then we should recommend that at the next election we revise our procedures. I think that it is too soon to decide whether or not the five-constituency experiment has failed, and I would certainly wish to continue with it for one more time.

DR JOAN TROWELL: I was intending to follow Kevin’s line. I was a member of the original Governance Working Group – at which time I suppose, to declare my interest, I was an appointed member and I am not an elected member for England. The idea has been eloquently expressed by our Scottish and Northern Ireland representatives: it is about local engagement; it is about having people from all over the country.

The Governance Working Group, way back with the old Council, was impressed by the number of people who were on that large Council who the public and the profession perceived as being based in London, and very little out in the regions.

Whether we have achieved anything differently with this one – we may not have achieved ethnic diversity, though we have gender diversity in proportion – I do not know that is, at the bottom line, what we are going to get. I would certainly contend the idea that because there are fewer places you will get fewer applicants. Certainly, for paid jobs in the medical profession, that ratio does not apply. It is what is perceived as the attraction of the post.

MRS SARAH BEDWELL: You are really stuck between a rock and a hard place at the moment. What you have to think about is that there are clear disadvantages on both sides. If you go to the compromise position in the middle, you need to think about what you are gaining in terms of advantages there. What you will lose is, as Ros said, the benefit of five constituencies and some sort of local engagement.

We can move to three constituencies. We have three draft constituencies. I have to say that I would be very hard-pushed, as an English person, to say that there was any real local engagement or anything that means anything in those constituencies, because they are so huge.

If you move to one, you will have a very long ballot paper, but you will have, we think, the benefits of diversity. There is no exact science to this at all, but I would caution compromise – about what you are gaining by compromise, in terms of advantages. There are real advantages and disadvantages on both sides. In the middle, you need to think through what you are actually getting.

PROFESSOR JANET HUSBAND: I am afraid that I have to leave in a moment, but I wanted to put on record my support for the three or five constituencies. I really think that a ballot paper of several hundred is not working. It actually comes down to guesswork in the end, if you are the person voting. We want to have as an informed vote as possible. I think that the only way is to reduce the number. So I would go for multiple constituencies.

DR NICKY TOYNTON: I agree with Kevin: there are very good reasons for us going to five constituencies. We have only done it once and I think that we need to do it again. I have been trying to restrain myself from talking about diversification and statistics, because I am in
a room with so many real academics and I am a GP who is not academic. However, I cannot
help but think that, if we are only voting for 15 people, one person makes such a huge
difference in the diversity figures. So is the fact that we are less diverse really just because
the numbers are so much smaller – rather than a real negative effect? I think that we need to
give it another go, and see what happens.

MRS FIONA PEEL: I have been mildly amused by the debate, because I really do not
understand the psychology here. Most of us going towards local engagement at the moment
have put that as a high priority, because we feel that it gives us some credibility for the job
that we do. So I think that the five constituencies are important for that reason.

Also, most of us at the moment think that we only like to vote when we are informed, and you
cannot be informed by 300 people on a single form. I think that those are two, really critical
things. I feel very strongly that one must be informed; one must have local engagement; and
just to change now is somewhat wrong.

It goes back to Peter’s point in some respects. It was Peter’s point plus Sarah’s – that the
papers will go out, saying far more clearly what these people are required to do. That is
another important element of reducing the number of people who will want to be put on there.
Although Sarah has been very mild in what she said must be on it, I still think that we have to
work more clearly towards the criteria of what we expect of them, and also put in there more
of the development stuff that we will need to put into these new members who come on.

With those caveats, we will get a more informed group of people who have put their names
forward; but I really do think that you cannot expect the doctor societies to vote for people
they have never heard of.

THE PRESIDENT: We have had a fair crack at this one, it seems to me. We have been
round the circuit at least once. It does not sound to me as though we are going to deal with
this on a consensus basis. I am happy to try it again if you like, but it does not seem that way
to me. I guess that we are therefore moving towards a vote. I know that we have tried to
avoid votes in the past, but it does seem to me that we have been round the circuit here and
we should come to a definite decision.

There is a substantive motion on the paper, i.e. that there should be a single constituency.
My suggestion is that we vote on that. If that is carried, that is fine. If it fails, we will then
have to think in terms of proposals for either a five or a three.

DR BRIAN KEIGHLEY: Or just pass to next business – the status quo.

THE PRESIDENT: Unless somebody proposes a three, the status quo will stand.

MR FINLAY SCOTT: The position is that, unless someone makes a proposal now which is
seconded, you will vote on recommendation 2b. If it is passed, it is passed. If it falls, we
move on to the next recommendation. Standing orders do not provide for an alternative to be
put at that point.

The first thing that you have to decide is whether someone wants to propose another
recommendation, on which you will have a vote. To be more to the point, if anyone in the
room wishes to propose three, then they should do so. It has to be seconded, and we will
have a vote on that. If that falls, we then move to the substantive recommendation that is
already before you. That is the order.

DR ROSALIND RANSON: What about the five?
MR FINLAY SCOTT: Five is the status quo. It survives. We are where we are. It survives, unless it is changed. That is the position.

THE PRESIDENT: So we are looking for somebody to suggest a number other than one or five. [Dr Edwin Borman proposed.]

MR FINLAY SCOTT: We have a proposal from Edwin that there should be three constituencies in England, the details of which would be established separately. The question is, do we have a seconder? [Dr Krishna Korlipara seconded]

In which case, there is a proposal on which you should now vote.

DR EDWIN BORMAN: There are a number of other recommendations which we have not yet agreed on. Perhaps, for the purpose of clarity and not least because they are pertinent to the running of any election, we ought to deal with those too.

THE PRESIDENT: There has been a proposal. We need to establish whether we are agreeing on three or not, and then move on to the substantive recommendations.

DR PETER TERRY: Can we assume that there is no West Lothian issue here?

THE PRESIDENT: I was going to come to the West Lothian issue. People who are members of Council have the right to vote, but only people who are members of Council have the right to vote. All members of Council have the right to vote.

The motion was lost, there voting 2 for, 23 against, with 1 abstention.

THE PRESIDENT: Can we now have a vote on the substantive recommendation, which is that there should be a single constituency in England.

The motion was lost, there voting 9 for, 16 against, with 1 abstention.

THE PRESIDENT: That too is lost. So we are back to the five-constituency model. Sarah, do you want to take us on to recommendation 2c?

MRS SARAH BEDWELL: This is a slightly technical point, but it is important. I will therefore do my best to explain it. There are various findings and convictions that candidates have to declare, and they go onto the ballot papers. As things stand, the cut-off point for the declaration is effectively the point at which you submit your ballot paper. That means it is variable from candidate to candidate. So if you submit your ballot paper very early and then you are convicted of a criminal offence, that will not be declared.

Clearly there has to be a cut-off point for it. The cut-off point should be consistent for candidates, and logic suggests that it is the end of the nomination period. It might mean that somebody has to submit a declaration after they have submitted a nomination form. That is the downside of it if there are two bits of paper, but it does mean that everybody is treated fairly and, equally, voters know exactly what is happening about everyone.
THE PRESIDENT: Are people content with that? It seems sensible to me. [Agreed]

MRS SARAH BEDWELL: The final recommendation is a timing recommendation. I do not think that I need to say very much about this, except that we will need to take a decision once we know what is in the ministerial statement about whether or not to go ahead with the consultation.

As I said before, in answer to Rob’s point, we would need to take that ahead of September, because September will not give us sufficient time to consult. We are asking you here to delegate to the Regulation Reviews Steering Group.

THE PRESIDENT: Are people content with that? It is a practical solution to a problem.

DR JOAN TROWELL: If we have in fact, as I believe we have, just voted to maintain the status quo, do we have to consult?

MRS SARAH BEDWELL: Yes, you have a consultation on your first decision, on the public interest declaration.

DR JOAN TROWELL: I had missed that one. We did not have a vote on that.

THE PRESIDENT: Nevertheless, it was the decision!

PROFESSOR CHRIS BULSTRODE: Can I thank you for being involved in the most expensive vote I have ever been involved in? I do not know how much this equipment cost but, in my memory, I think it is the first time that it has been used.

THE PRESIDENT: It is certainly the second in my memory. It is the first time it has worked successfully, I think!
3. Chief Executive’s report

MR FINLAY SCOTT: I have very little to say about my report. I would however like to report just one additional piece of good news, which is that we are making very good progress with the disposal of 44 Hallam Street, which as you know is a building that has been with us since 1920. Neil and his colleagues are taking the opportunity adroitly also to dispose of a building that you have never heard of, namely 14 Hallam Street, the lease to which was acquired as an aberration, I have to say, before I arrived. I would like to make that clear.

We have advertised the building at 44 Hallam Street for disposal. There has been serious interest. It is proceeding apace, and it looks as though the disposal proceeds will both exceed our expectations and, as part of a package deal with the landlord, enable us to dispose of 14 Hallam Street – which has been something of an embarrassment. So that is very good news and it is “well done” to Neil and his colleagues.

Perhaps I ought also to mention the financial position that is reported in Annex D. As we advised at the most recent Council meeting, revenue this year is below expectations. There are a number of explanations for that. Fortunately, expenditure is also below expectations but the combined effect is that the budgeted deficit, which we thought would be about £7 million by the end of the year, looks as though it may rise to the region of £9 million.

There are two things. The Resources Committee will be receiving further reports on this next week at their meeting, and we will be describing the further steps we are taking to contain and reduce the expenditure where appropriate; but also to remind you that, even on the current projection, at the end of 2006 our reserves will amount to £24 million and we will have about £50 million in the bank. So the increase in the deficit which comes from the reduction against budget in our revenue is not in any sense a crisis item. It does however underscore the importance of what the Resources Committee has been doing, which is requiring us to look energetically at all areas of expenditure.

I have to remind us, however, that the link between the income we receive and what we spend is not particularly clear in this organisation. Only in relation to the PLAB test – quite a small operation in fact – is there any clear relationship. Obviously we will bring further reports to you as the year unfolds.

Beyond that, I think that the operational statistics in the report demonstrate that my colleagues are on top of the operational challenges and delivering good-quality services – all of which must be a good thing to be able to say at this particular time.

THE PRESIDENT: Are there any comments?

PROFESSOR CHRIS BULSTRODE: Can I, through you, congratulate the Chief Executive on this, and particularly on the targets with registration and fitness to practise? Now we have a director of education, however, can I ask you to turn your beady eye to some targets outside of registration and fitness to practise and to start setting targets in the other areas where we should be very active and to see whether we can also get them going as fast?

MR FINLAY SCOTT: I happily accept that challenge.
DR EDWIN BORMAN: I know that some people would rather that that history does not proceed for much longer but there is a history of about 150-odd years, part of which is at Hallam Street. What arrangements will be made for some of the paraphernalia related to the history of 44 Hallam Street’s GMC period to be transported through to our 21st century offices?

THE PRESIDENT: The window with my name on it?

MR FINLAY SCOTT: My first thought was that, in order to reduce our energy bills at the new building, we might burn some of it! But I think that Brian – who has rather more conservative tendencies than me, in more ways than one – may want to say something.

DR BRIAN KEIGHLEY: I echo Ed’s concern. There are quite a few artefacts there and I think that they should be preserved in some way. I have made suggestions when we were designing the Council chamber. I know that Finlay is not as sensitive to history as perhaps I am, but I think that we have a legacy there and I think that some artefacts should be preserved in a proper way.

MR FINLAY SCOTT: Perhaps I could say two things. We certainly do have a legacy there, which is why I would quite like to leave it behind. More seriously, however, Neil and his colleagues are making appropriate arrangements to preserve that which sensibly should be preserved.

MS RUTH EVANS: Can we come back to the stained glass?

MR FINLAY SCOTT: Neil, do you want to say something about that?

MR NEIL ROBERTS: We will not discard any aspects or items from 44 Hallam Street. We will preserve all that we can. The window will remain where it is in the building.

MR FINLAY SCOTT: Ruth, was that sufficiently clear? The window will be staying at 44 Hallam Street.

MS RUTH EVANS: That is the only thing that we should take.

MR FINLAY SCOTT: 44 Hallam Street is a listed building and we would not be able to remove the window without, in effect, replacing it – and it is hugely expensive.

MS RUTH EVANS: Have you costed it?

MR FINLAY SCOTT: Yes.

MS RUTH EVANS: I am not sentimental, but the glass is incredibly important to our history, heritage and culture. It is the only thing that is, I would suggest, in that building. If there was a way of taking it out, I really think it is an important item for us.
**DR KRISHNA KORLIPARA:** I think that the majority of us would agree with that. It would be a great shame to discard that. Those who do not give enough attention to it are unaware of the importance of it in historical terms. Quite frankly, whatever the cost, I think we ought to keep it for posterity.

**MR FINLAY SCOTT:** As always, we will do Council’s bidding. But I have to say – and this is not the function of my earlier jocular remarks – it can be argued, and I think this is where English Heritage will come from, that the window is an integral part of that listed building. That is the framework within which we would have to operate.

However, if your collective wish is that we should go back to it again, even at this late stage in the negotiations with the landlord, then we would be very happy to do so.

**THE PRESIDENT:** I think the idea is that we explore the possibility. Let us see what the situation is and then we can make a decision when we know what the possibilities are – including costs, and what we would do with it if we got it.

**DR BRIAN KEIGHLEY:** There is an alternative, President. That is, to leave it where it is in situ, but to recreate it on a fresh piece of glass – not stained glass. Some of the coats of arms and names could be done at a lot cheaper cost than taking the actual stained glass out.

**THE PRESIDENT:** My personal view is that the window is preferable to many of the portraits – but that is my only view.

**DR EDWIN BORMAN:** I do apologise for raising the subject! I suspect that I will be strictly spoken to afterwards. However, I am going to take it further. For those of us who are interested in such matters, and I think that we have identified ourselves by speaking, could we have a report from Neil as to what the proposals are, so that we might have some oversight of the issue? That would give us the opportunity to put our oars in a little bit more, if we so wish.

**THE PRESIDENT:** Council would then be making a decision in knowledge, rather than just on speculation.

Alex, is this about the window?

**DR ALEX FREEMAN:** No, it is not about the window – although I do agree with what has been said about that. The portraits, busts, and everything like that – I am tending to agree with you about that, but I am sure that they should be preserved. If we do not want to keep them, perhaps they should be offered to a suitable body who would undertake to preserve them.

There is also various archive material, printed copies of the Medical Register going back to the year dot, and things which are really important archive material. If we feel that we cannot keep them, then they must be offered to some suitable organisation that would undertake to preserve them for the nation.

**THE PRESIDENT:** I agree.

**DR PETER TERRY:** Personally, I very much doubt if we would be able to take that window out. I certainly do not support any degree of expenditure on doing so, even if we could.
As for the other artefacts, I think that they should be very liberally shared with our Manchester office. We have a nice new office in London, with a modern aspect, nice and light. I really do not want all that doom, gloom and rubbish cluttering up what I think is quite a nice, modern space. So let us share it with the Manchester office.

THE PRESIDENT: I am sure the Manchester staff who are watching this broadcast as we speak will be very grateful to you for that suggestion, Peter, and will look forward to seeing the artefacts in their office in the near future.

MR ROB SLACK: I wonder if I could get back to other matters which are in the Chief Executive’s report.

I apologise for not having given you notice of this question. You may wish to delay it to the next meeting. However, under “Key aim 4: Further improve our processes for protecting patients...” – you do not need to look at it actually – I wonder if you could say anything about the ongoing processes that are in place and how successful they are on appraisal of the panellists. Is there an effective process for making sure that those panellists are still fit to do the job on a continuing basis?

I do not necessarily want an answer now, but I wonder if it is something you might address in the future.

MR FINLAY SCOTT: Even if you had given me notice I think I would probably have said that it is a question better answered by either Gillian or Paul Philip.

THE PRESIDENT: I think that there have been developments which we should perhaps just touch base on. Paul, do you want to start?

MR PAUL PHILIP: I am very happy at least to make a start on that question. The Fitness to Practise Committee meets in about two weeks’ time. It will receive a paper proposing exploration of appraisal arrangements for panellists.

It is clear that, within panellists themselves, there is a lot of concern about assessment processes and about the need for ongoing appraisal in relation to the important work that they do. As such, the paper will be received by FPC in two weeks’ time. It will propose a short-life working group, probably with some members and some panellists, to explore in some detail what an appropriate arrangement might look like and how much it might cost, with a view to attempting to have something in place probably shortly after the New Year; if not, end of the winter.

THE PRESIDENT: Do you want to say anything at all about the meeting of the forum that you had a couple of weeks ago?

MR PAUL PHILIP: Okay. The panellists, or some of the panellists it has to be said, have formed themselves into what they call a Panellists’ Forum. The Panellists’ Forum was, as I understand it, the result of an election by some panellists. They have appointed four of their members to meet with members of staff. Grazziella, Scott Geddes and I have met with them about a month ago now, and we had a very amicable meeting. We intend to meet with them approximately once every six months.

From our perspective, anything that improves communication between the now some 400 panellists that we have and the Council is to be encouraged. What we are not too sure of is
the extent to which such a vehicle or mechanism actually represents all panellists. As you know, we have a series of training sessions with panellists throughout the year – I think that there are six, if I recall correctly. At those meetings Council members have very generously given their time to go along and meet the panellists directly.

That is our stated intention, in that we want to hear the views of all panellists, not just three or four panellists who were elected from within. Therefore, we intend to work with both vehicles.

THE PRESIDENT: Rob, are you happy?

MR ROB SLACK: Yes, I am reassured that there is a process going forward to make sure that the panellists are behaving appropriately and going about their job to give the best possible judgments.

I wonder whether, when you put together this group, you might include some of the counsel or the solicitors involved, to get their opinion as to how they might appraise panellists. I could perhaps talk to Paul about it in more detail.

THE PRESIDENT: Thank you, Rob.

MRS FIONA PEEL: May I make a totally different point? It is just an observation, which is perhaps a little self-indulgent. When the Education Research Committee met last week, we were very concerned about the amount of money that we are spending on research.

At some point, could the Board have – perhaps divided off here – an element of how much money we are now beginning to spend on research? All of us who have been involved in those groups think that it is something that the GMC should be developing and be quite proud of, and that we do need to put some money into seriously developing our future. It might be helpful for the Council to know how much we are putting aside for research. I know that Professor Bulstrode would probably like a lot more put into it.

THE PRESIDENT: I take it that we do not have access to that information just now, so we can provide it for you.

DR ARUN MIDHA: My recollection is that at the last Resources Committee we did raise this subject, so our eye is on the ball. The Resources Committee does recognise that there is a desire to direct money in those ways. With a new director on the Education side as well, we can work much more closely with Education.

MR FINLAY SCOTT: What might be helpful is if I talked with colleagues about bringing a short information paper on research to the next Council meeting, which would include the planned spend for this year against budget. Then, when we are working our way through the budget processes for 2007, we could certainly make sure that both the Resources Committee and indeed the Council itself have an opportunity to signal whether it is thought that the investment in research is adequate.

MS SALLY HAWKINS: This is about the fitness to practise performance. I wonder how often we look at our targets and tighten them. When you get 100 per cent on something repeatedly – which is great – it suggests to me that actually we should be making a bigger stretch. I wonder how often we do set that stretch in.
THE PRESIDENT: I am not sure there is a specific answer. I suspect that it is done differently by the different committees. The statistics for fitness to practise are looked at on a regular basis by the Fitness to Practise Committee and that debate takes place there, presumably.

MRS GILLIAM CAMM: Yes, we have been looking at it and have been making progress on it. We have that discussion virtually every time we have the figures.

THE PRESIDENT: They were not always at 100 per cent. It did not start off at 100 per cent. There have been improvements to get to that level.
5. Revised Good Medical Practice

THE PRESIDENT: I guess the meet of today’s meeting is the revised text for Good Medical Practice. I guess that nothing we do is really more important this year, at least as far as the outside world is concerned, as getting this right. It matters critically both for patients and for the profession itself that we get the wording, the concepts behind this, right.

This is probably the third time that we have looked at it – the first time in a formal Council session – so the text should be familiar to us. There have been modifications as we have gone along, although fewer and fewer as the months have passed.

Do you want to take us through the relevant points, John?

DR JOHN JENKINS: I do not want to repeat in great detail what is in the paper, because I know that members have read it and, as you say, President, we have been over some of the ground before.

However, I think it is important for us to take stock of where we have got to with the current document. I know that I wave this at you regularly, but this might be the last time in formal session that I will wave this particular version of it – just to remind us of the way in which the existing document has already been used, accepted, and indeed lauded in many national and international contexts. We are not starting from nothing, therefore; we are starting from a document which has already done a lot of good.

Two years ago we decided the time had come to look at this again, however, and that there were areas in which we felt it could be improved. The working group that is referred to in paragraph 6 of the paper was a very widespread working group, and I am very grateful to all those external bodies who nominated representatives to join that working group, in addition to members of SEC and of other groups within Council itself. We had very widespread involvement in the redrafting process, as well as in the extensive informal and then formal consultations that are detailed on the remainder of that page of the paper.

We then went into a process of the redrafting of the document itself. We have, as it says in paragraph 13, documented all of this, because we feel that this process that we have gone through is worth recording. The outcome is one aspect of it, but the very fact that we have put in place this detailed process which has involved so many different people in so many different ways, and has genuinely sought to consult and to take account of the views expressed to us during the various strands of consultation, we felt was important. The account of the review is in Annex C and a more detailed account of that is available from the office and will be made available on our website, which may be of interest to other groups within Council or even to some external bodies that are contemplating something similar in the future.

As paragraph 14 says, we also undertook an external audit of the process and we are very pleased with the outcome of Mr Harrison’s report and his conclusion that we had taken on board effectively the consultation responses.

The discussion – paragraph 15 – reminds us that, although many of the principles have been enshrined in the new version of Good Medical Practice, we did feel that there were some areas where we needed to develop it and take it forward. Paragraph 16 picks up on three of those, which are then expanded in the following paragraphs: the partnership issue, the equality and diversity issues, and the current treatment of children. I will not go through the
detail of that, but merely to say that the other context in which we looked at all of this was the raising of the profile of professionalism in recent times. We looked very critically at Good Medical Practice as to its contribution to medical professionalism, and to the development and sustenance of that as an important concept for the profession.

We also looked at the duties. This is the first revision of the duties since the original publication of Good Medical Practice. Paragraphs 20 and 21 point out how we have also modified the introductory statements and, particularly at the end of paragraph 21, I think it is important to recognise that a criticism in Sir Liam Donaldson’s report was the use of the word “may” in the introduction to Good Medical Practice. In fact already, long before that report became public, we had changed the word “may” to the word “will”. In response to our very early informal consultation, we had already made a clear decision and the formal consultation document – which of course went to all of the Departments of Health in the UK at the beginning of the formal consultation – had already been changed in this respect. It did come as something of a surprise to us that it was in the CMO’s report, given that we had already taken this particular issue on board.

Summarising before we come to the first recommendation, therefore, the working group and the consultation process has led us to the draft that you see before you in Annex B today. I cannot pretend that every word and every line of this is agreed to by everyone, and I am sure you will have recognised that this can never be the case in a document like this. In a sense, it is a consensus; but we believe that that consensus is a very broad consensus and it has taken account of the comments – particularly those, I have to say, of Council members when we had our informal seminar in July. We have attempted to build those into the document wherever possible.

There will still be one or two minor final changes. Two things have come in to the office just this week, since this draft was sent out to you. The first was some comments regarding the English and the use of English. We want to make the document as accessible as possible. There have been one or two helpful comments there that we would like to incorporate, but none of them change the meaning or the substance of the document.

The second is that we had legal comments. We felt that it was important to run the document past senior counsel, to get a view as to whether there were any elephant traps for us in terms of potential legal challenge. There are two paragraphs to which I would draw your attention where we feel that a minor amendment to the wording, in response to this legal advice, might be worthwhile.

The first is paragraph 19 which is on page B12. This is in respect of the issue of references. There is no comment about the first sentence of paragraph 19, but the second sentence raised the concern that when we use the words “which has any bearing” this might be too broad and might be challenged as information – perhaps about the health of a doctor being put into a reference where it was not material, and so the proportionality test might have to be raised against that.

I am suggesting therefore that we reword the second sentence as follows:

“When providing references you must do so promptly and include all information that is relevant to your colleague’s competence, performance and conduct”.

So it is removing “any bearing”, but still retaining the meaning of the sentence. I am sorry I have not been able to give that to you in writing but, as I say, this came in only within the past couple of days.

THE PRESIDENT: Do you want to pause there, John, and see if anyone has any concerns about that? It seems to be a relatively minor modification. Are people content? [Agreed]

DR JOHN JENKINS: Equally, I do not think that the second one is major. It is in paragraph
33 on page B16, in the section on maintaining trust. Again, perhaps I could read to you our suggested redrafting of paragraph 33.

“You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways which exploit their vulnerability or which are likely to cause them distress.”

Again, the issue here was whether the wording as it currently exists was perhaps too wide and that this might inhibit doctors who were giving a genuine opinion, because they were a doctor. They were not there to give an opinion on behalf of the medical profession but, because they were a doctor, they were perhaps asked at local level to take part in a panel on something, and they were expressing personal opinions in a very general sense but not directly in relation to the individual care of a patient. So the feeling was that we could continue to protect patients and make it clear to doctors that anything they said in this context should not exploit the vulnerability or cause distress to patients, but that we should not be seen to be curtailing doctors’ freedom of speech in a more general way.

THE PRESIDENT: Are people content? [Agreed]

DR JOHN JENKINS: What I am asking you when I come to the first recommendation, therefore, is to approve the draft before you, but with the minor changes which I have described to you and, indeed, any which you may now wish to bring to my attention.

THE PRESIDENT: We are looking at the whole of the text now. We are not going to go through it bit by bit in the way we did before. Are there comments on the draft in front of you?

DR BRIAN KEIGHLEY: I have just one comment, and it is difficult to bring it to people’s attention at this late stage. There was one sentence which made me a little uncomfortable, however. It is in paragraph 38, about ending professional relationships with patients.

It seems to me that there are circumstances where a relationship can break down where it is really in the patient’s interests that one should end that relationship. If you go to the second sentence, it tends to suggest that the only justification for ending this relationship would be violence, stealing, or unreasonable conduct on the part of the patient. It seems to me that there are circumstances which are completely unrelated to these issues, and it is my opinion that that paragraph would read very well without that second sentence.

DR JOHN JENKINS: What we were trying to do was to exemplify some of the circumstances. I agree with Brian that the first sentence is the key sentence, because it does not limit it in that way.

On the other hand, what we wanted to do was to say to doctors, “This cannot be on the basis of trivia. These have to be very significant things”. I think that the second sentence is important from that point of view, because it helps to clarify that there has to be a serious level of breakdown of trust before it would be reasonable for this action to be taken in that particular context, but it does not limit it to that context.

DR BRIAN KEIGHLEY: The way I read it, it almost seems as if this advice is predicated on primary care rather than secondary care. A surgeon would not end a relationship with a patient if he had found that the patient had stolen something from the ward. That would be something that management would do. It seems to be primary care-oriented.

I think that these issues are well dealt with in the specialty-specific guidance that we have done in Good Medical Practice for GPs, and I think that is where that elucidatory comment
should be – and not in the text. We are stating principles. I think that we get into danger if we start giving examples, because they are not all-inclusive. They tend to allude to one branch of practice and not others. We should be stating principles, and I think it is superfluous and makes it difficult. Others may not agree.

THE PRESIDENT: I guess the issues that led to this, though, are patients often living in remoter, rural communities who can find themselves really disadvantaged if they are removed from a list. Secondary care must be less of a problem in that sense.

It is the point John made: how do we make it perfectly clear that there must be good grounds for doing this if the doctor is taking the initiative? If the patient takes the initiative, that is fine. For the doctor to take the initiative there must be good grounds.

I agree with you that examples are always difficult. You can make exceptions to them, where you can argue your way round them; but the principle must be that, as John said, there must be a robust reason for doing this. Have I got it right, John, that is the thought behind it?

DR JOHN JENKINS: Perhaps I could add this. This is not new; this is something which has been in the document. We have not changed this particular section.

THE PRESIDENT: Are you content to leave it, Brian, given that you did not spot it for the last 15 years? [Laughter]

DR BRIAN KEIGHLEY: Thank you, President!

PROFESSOR CHRIS BULSTRODE: May I apologise for bringing this one up at a late stage? However, I think John knows about it and I think that you know about it, President.

One of the things that I have done since this came out into the public domain is to carry it around in my briefcase and to have shown it to lots of people, because I am passionate about it and I think that it is an important document. I had some rather peculiar feedback from a couple of people, which I thought was important. They said, “This is a really strong document but it is weakened by a couple of sentences”, and that is what they wanted out.

On B4, line 6, “…the principles in Good Medical Practice might apply in practice…”. They suggested that we change that to “applies”. The “might” weakens it.

Similarly on the next page, that very last sentence, “Serious or persistent failure to follow this guidance will put your registration at risk”. They read that as saying, “It doesn’t really matter, everything that is in here, unless you do it again and again or seriously. So please don’t worry about it, you doctors. Everything is going to be all right really, although this does look quite a strong document”. I had not read it like that when I looked at it, but that was the feedback I had from a couple of lay people. I thought I ought to bring it to Council because, again, it is this business about how other people perceive doctors: not necessarily how you see them yourself.

THE PRESIDENT: Thank you very much. You did let me know and I had a word with John about your concerns yesterday. John, do you want to pick up the two issues Chris has raised?

DR JOHN JENKINS: I am thankful to Chris for allowing me the opportunity to think about this before having to speak completely on my feet.
On the first point, on page B4, it is certainly arguable whether the word “might” is necessary or adds anything. I have no problem at all with that. I do not think that it changes the meaning in any negative way, so I am fine with that.

There is more of a problem with the point about the final sentence on page B5. The way it is worded at the moment is a strengthening of the current document, in that we have changed the “may” to a “will”, as I said in my introduction. It does reflect real life, and I just have a concern that if we change it by taking out “serious or persistent” we are saying something which is not actually true – because that is not the way in which our fitness to practise procedures operate.

THE PRESIDENT: You are happy with one out of two?

PROFESSOR CHRIS BULSTRODE: I am done well!

THE PRESIDENT: It is better than your usual hit rate, I have to say! Are the rest of the colleagues around the table content to take the “might” out of page 4. [Agreed]

MR ALAN HARTLEY: Can I just remind Council that the revision of this document has been through goodness knows how many hundreds of hands and organisations, patient groups, the Patient and Public Reference Group, et cetera?

I, for one, think that this particular thing on B5 is important. It is clear. There is no argument. I have bandied the document about as well. I think that my GP is sick of looking at it. To my mind, it spells it out and I do not think that it undermines the document. It is clear – “serious or persistent”. There are some things in there as guidance and they are simply guidance. Clearly you can get dragged over the coals for those sorts of things.

However, please do not forget that this document has been pored over, not just by the GMC but by hundreds of people.

THE PRESIDENT: I think that what we are suggesting is that we keep the phrasing on page 5 and that we take the “might” out of page 4. Are we content with that? [Agreed]

DR ALEX FREEMAN: About paragraph 35, which is about your reference number and your registered name, I am not very clear about the second sentence and the extent to which you must use your registered name. Is that your full name? Some people are known by different names at different times. It is a “you must” one, and the name on my prescriptions is not my registered full name; it is a shortened version which I use. I am not really clear what that second sentence actually means.

I have no problem with people being able to identify me. I am quite happy to identify myself, but it will be rather a “faff” to put my complete, full registered name on it when it is only recently that the GMC database has been able to cope with it.

THE PRESIDENT: That is not what it actually says in the paper, though. What it says is, “You must make your registered name and GMC reference number available to anyone who requests them”.

DR ALEX FREEMAN: No, it was the second sentence that I was confused about.
THE PRESIDENT: We have been round this one several times, because of complex and complicated names. What is the answer to Alex's question, John?

DR JOHN JENKINS: I think it is a fair point that Alex has raised, but it was not the intention of the way in which it is drafted to make life more difficult for doctors; it was simply to ensure that, if doctors were known by a variety of names, it was the registered name that was the one that they used in any formal context, and that would include signing prescriptions.

Whether “the registered name” means that you have to include all 16 forenames – for those of us who are blessed with that – I do not think that was ever our intention. It was simply that if we were to be recognised, then our registered name was the way in which we would be recognised.

It is possible to read that into it, but it was not the intention and I am not sure whether, because of that, we need to make that clear.

THE PRESIDENT: Is this different guidance from the guidance in the current code? It is new.

DR ALEX FREEMAN: John has just given an excellent form of words which would completely clarify what that sentence means. Could we not use those words instead? “Where you are known by more than one name, you must use the registered name....”

THE PRESIDENT: Can we ask you to take it away and see if you can deal with it, because I suspect it may cause confusion?

DR JOHN JENKINS: We are very happy to do that. Certainly if we can clarify it, we will do that.

PROFESSOR PETER RUBIN: This is just a simple process thing. In the links you have quite rightly pointed out that, where there is a four-nation issue, the relevant information would go in. I noticed, when Brian was raising his issue in relation to paragraph 38, “NHS trusts” are mentioned. That will raise hackles in certain parts of the UK. It is just to reinforce the need to go through this very carefully, four-nation-proofing it.

THE PRESIDENT: Well spotted. Thank you.

DR JOHN JENKINS: Can I take it that we have approved recommendation 2a?

THE PRESIDENT: It looks to me as though we might have just done that, yes.

DR JOHN JENKINS: In that case I am very happy to move on to paragraph 23, which is to say a little more about where we go from here. I will not go through this in any detail because you know about the links. We have set those out in some detail on page 5 of the paper.

We feel that the strength of the new version of Good Medical Practice will be much clearer links to other GMC documents and to other external sources of advice and information. We are also currently developing supplementary guidance and we are working on that, particularly in the four pieces that are listed in paragraph 28.
Before I come to the second recommendation, I would again point to paragraph 27 and the work that we are doing with the Disability Rights Commission, who are undertaking some work which will not be an internal GMC document but which we will be able to link to, to pick up the particular relevance of Good Medical Practice to their work.

The second recommendation is at the end of paragraph 31 and relates to the fact that we will be launching Good Medical Practice towards the end of October 2006. In order to do that, we would like to have the four pieces of supplementary guidance also available, to link to at that time. We feel it is important that they are there. However, that will be before our next Council meeting. We are therefore asking your approval for the President and myself to approve the final text of those four pieces of supplementary guidance, based on their consideration by the Standards and Ethics Committee in a few weeks’ time, and then on an email round robin to which we will give all Council members the opportunity to contribute before we finalise the text.

THE PRESIDENT: Are people content with that way forward? Are you happy to remit it to John and myself to finalise the document before it goes out? [Agreed]

DR JOHN JENKINS: We think that the online version, as I demonstrated to those who were able to come to the July seminar, will be the really important new development with Good Medical Practice and the way in which we can find seamless access to a lot of other information.

We have taken on board the point that was made at that time about external guidance, and there will be a disclaimer built in when it is not GMC guidance. I would reassure you about that, therefore.

That takes me on to page 7, the launch of Good Medical Practice. As I have said, at the moment we are planning that for the end of October. We have a process already in hand in relation to trying to get some public profile for that, because we believe that this document will not only be of interest to doctors but will also be of interest to members of the public – and Alan has kindly said some things about that already.

The final section of this paper is about implementing Good Medical Practice. As you know, it is already being used in many ways in that respect. We will be meeting with key stakeholders to explore ways in which we can further embed the principles in Good Medical Practice in all aspects of doctors’ professional lives. Again, helpful suggestions were made at our last seminar about, for example, medical schools. Chris has raised the matter of undergraduate medical education. We fully accept that and hope that we can move it forward. Sally made some comments about trusts and complaints procedures. We have not forgotten about that. We feel that there is a lot we can usefully do there, and we will be taking that forward.

Finally, referring to paragraph 42, in his report Sir Liam suggested the concept that Good Medical Practice could develop or evolve into a code. I want to confirm that that is not how we see the document itself. We do not see that being the useful nature of the document, both for doctors and for patients and the public. However we do, in a very positive way, see Good Medical Practice providing the foundation for all of this other work, which will then "operationalise" the guidance, the principles, and will make it possible for them to be used in all of these other ways.

We fully accept the principle in what Sir Liam is suggesting, therefore, but we do not quite see it in the way he perhaps envisages it. That is something which I thought it important for Council to understand and, hopefully, to confirm that that is the positive way in which we will take this document forward, for use in many different arenas, both internally and externally.

In finishing, I want to pay tribute to the working group. Many of you were involved in this work. Others, like Alan, came in and helped us from external bodies. It was a really
enjoyable process. It has gone on for two years – probably enough said! However, I cannot leave it without expressing my thanks to the staff. Jane and Yael are both here today, but the team who have worked on this document have done so consistently in an absolutely superb and outstanding way over this two-year period. The document we have approved is testimony to the quality of the staff that we have working for us in this part of the organisation.

THE PRESIDENT: Thank you very much indeed. It is great to see a project like this coming to fruition, and I hope the launch is successful and that it works well.

MR STEPHEN BREARLEY: I trust that all those who have been involved in developing this new version have got the message that their colleagues are very pleased with what they have done, but it does no harm to say it again. It is a superb document and everybody who has had a hand in it has every reason to be proud of what they have done.

I just have one, slightly pettifogging point, President. I cannot remember if this is the third or the fourth version of Good Medical Practice, but there has in the past been scope for getting confused about which version is which. I wondered whether we ought to go with the times and call this New Good Medical Practice! I rapidly decided that was not a particularly good idea. I trust that when this is published there will be something in a prominent place, saying “This new version of Good Medical Practice was published on such-and-such a date and supersedes the previous version”.

THE PRESIDENT: Yes, we have had discussions in this Council before about making sure that there are dates on the publications. I am sure we will pick that up. It is an important issue.

Thanks again to you, John. It is quite important that you maintained the momentum that you did over the two years. I know how difficult that can be.
GENERAL MEDICAL COUNCIL

COUNCIL

Wednesday 1 November 2006


THE PRESIDENT: You know my view. We seem to discuss the Business Plan every two minutes but, here we are, back again.

It is quite important that we get this organised sensibly. It has changed a great deal in the last two or three years, pretty much in line with the views expressed by Council. We need to have a clear understanding of what it is we are committing ourselves to in the next few months. Paul, are you going to start the discussion on this?

MR PAUL BUCKLEY: This is a working draft of the 2007 Business Plan. Council will be invited to adopt the Business Plan formally at the December meeting, but we thought that it would be helpful to bring the draft to this meeting, to give an early indication of tone and content as we go forward.

I should start with an apology for a typo in the very first paragraph of the draft plan. This is on page A1, paragraph 1 – perhaps inauspicious! Originally, we said in the first sentence, “The GMC is the independent regulator for doctors in Great Britain and Northern Ireland”.

We changed that to “UK”. Unfortunately, we failed to correct it. It is particularly important, with the CMO there, that we get that right! We will correct it.

THE PRESIDENT: It is a little like “New York, New York” – you cannot mention it often enough!

MR PAUL BUCKLEY: I should also say that we are grateful to a number of members for advice on putting together the draft Business Plan; particularly to Ann Robinson for a number of very helpful suggestions. I would just remind members that this document is an externally facing summary of what the GMC does, which is produced mainly for the benefit of those outside the organisation who take an interest in what we do.

Sitting above it is the Council’s overall strategy and, beneath it, are the detailed operational plans for the various directorates within the GMC. So this is a top-level account of what it is that we are about.

For the purposes of the 2007 plan we have retained substantially the five key aims that we have had throughout 2006, but we thought it helpful to revise the wording of them, to make them focus more clearly on outcomes rather than on process. We hope that they are more meaningful in terms of what the Council’s priorities are in terms of achievement, rather than in the way that we are carrying out our various activities.

I think that is all I want to say by way of introduction, but clearly we would very much welcome comments, whether now or subsequently by email, probably focusing on the key aims and on
style perhaps, rather than on detailed drafting.

**THE PRESIDENT:** Ann, you have been helping behind the scenes on this. Do you want to say anything?

**MRS ANN ROBINSON:** I think that this is a very good first attempt, and I think that it is right to regard it as work in progress.

**THE PRESIDENT:** Four out of ten, you think?

**MRS ANN ROBINSON:** No, it is more than that. It is actually quite a good job – for where we are now. Where I think that it needs to change, however, is perhaps more in the language and a bit more focus on the outcomes, rather than describing process. I think there is more to do in that area.

I have already mentioned it to a couple of people. I am looking at the new guidance as to how to complain, but I think that we miss a trick if, for example under the **Key Aim Two**, we do not do something about continuing to work on the complaints processes, to make them more accessible and easily usable by people. Again, from the point of view of the public, that is something that they would be very interested in. That is all I really want to say at this point.

**DR JOAN TROWELL:** I am not sure if this is drafting and it echoes a comment I made yesterday. On A1 under 2(b) I would like to see us “Support and develop the **good medical practice** of doctors” – again, as a reference to our own publication and the work of our Standards Department.

**THE PRESIDENT:** Several people spoke to me last night – Joan was one but there were others too – about the need to make sure that we do emphasise our own publications through all of these things. I think that we should remember to do that.

We often refer back to the Royal College of Physicians’ document on professionalism, but of course it depends itself to a very large extent on **Good Medical Practice**. We should perhaps be less shy and a bit more forthcoming about our own strengths, particularly this week.

**DR JOAN TROWELL:** The term “good medical practice” also focuses it more on the outcomes for patients. “Professionalism”, to me, sounds more like a trade union activity.

**THE PRESIDENT:** I do not want to get involved in a debate about professionalism, but I very much agree with that.

**MR STUART HEATHERINGTON:** My comment ties in very much with that. Specifically because it is an outward-facing document, under **Key Aim Four** on page 4, the link between
education and the setting of standards, I picked up on the fourth bullet –

"Begin the process of embedding Good Medical Practice into doctors' working lives, from undergraduate education, through postgraduate education, to continuing professional development, through a series..."

So making a very specific link, specifically because it is an external-facing document.

THE PRESIDENT: What about getting rid of the phrase, “Begin the process of...” and just saying, “Embed…”?

MR STUART HEATHERINGTON: Better still.

DR ARUN MIDHA: This is a really good document. In terms of Ann’s ideas on the outcomes approach, I do entirely accept that but I think that you will find it in the operational plans as well, because there will be lots of KPIs. It will be at that level as well that you will see the outcomes.

THE PRESIDENT: Yes, we need to build on this process as it goes through.

MRS ANN ROBINSON: You caught me slightly on the hop by asking me to speak first. There was----

THE PRESIDENT: It was deliberate!

MRS ANN ROBINSON: There was an important ingredient that I forgot to mention. Some of the points that have been made about emphasising some of our publications partly cover this, but I do think that we miss a trick again if, in introducing each of these major points, we do not have something about what we have achieved so far; what we have produced; and where we are going to next – because it sounds as though we are starting from here, and we are not. It will reinforce some of the messages that we want to get in the background in the coming months.

THE PRESIDENT: So it is a brief lead-in to it?

MRS ANN ROBINSON: Just a brief lead in, to say, “We are not starting from here. We have done a lot already and this moves us up to the next stage”.

SIR MICHAEL BUCKLEY: It seems a little odd to say in covering documents, “This is the plan against which we are going to report progress” when we do not report progress against
the previous year’s. So I think it would be logical to do that.

Secondly – and I hope it is not too much a point of detail – paragraph 6 on page A2 talks about establishing “a group for engaging with employers of doctors”, and that is not reflected later. I think that really belongs in Key Aim One. It is a matter of improving medical regulation by the workplace.

Thirdly, I think that we should reflect the importance we attach to this group by mentioning it in the bullet points in paragraph 5 – what we hope to get out of the establishment of this group. Otherwise, it is uneasy coupling; we do not pick it up. Having mentioned that as the first thing we do, we then do not have a bullet point.

THE PRESIDENT: I will come back to Paul, but I am sure that is absolutely right.

MS RUTH EVANS: It is a very good résumé of the activities to be undertaken, but I do not think there is much business in this Business Plan. If it is an outward-facing document, it would be terribly helpful for the public and the profession to understand – again it is an accountability point – what resources are available; where these resources are from; how we are spending them; and how we are going to achieve efficiency savings year on year. This plan is for this year, so it would be for that particular year.

You do not have to make it long but, if we are calling this a Business Plan rather than a Résumé of Activities, we have to put something in on resources, plus human resources I would suggest.

THE PRESIDENT: Let us pause there and let Paul respond to these points.

MR PAUL BUCKLEY: Taking the last one first, Ruth is absolutely right. I should have said that we would intend to have an appendix which set out the resource commitment for 2007 and how that will be allocated. Obviously that will emerge out of the budgeting process. So when we bring the document to you in December, we will have that.

On the other points that members made, they are all very helpful points and I am sure that we can reflect them in the further draft of this.

PROFESSOR CHRIS BULSTRODE: I do not see much on education here.

THE PRESIDENT: There is not much on education here, I guess is the short answer.

PROFESSOR PETER RUBIN: We certainly have a plan! This is down to tactics, is it not? At this point in the GMC’s history it probably is important to include in the GMC Business Plan what Education are planning to do and how it fits in with the greater GMC. So I think that tactically it would be important to have more about education in there.
THE PRESIDENT: I am not quite clear if you are volunteering to produce something for the next version of this document. Is that what you are suggesting?

PROFESSOR PETER RUBIN: Broadly speaking. Not personally, but on behalf of others, yes!

THE PRESIDENT: I think that would probably be welcome then. Is it welcome, Paul?

MR PAUL BUCKLEY: Very welcome.

THE PRESIDENT: I feel that I am walking on eggshells with this particular issue, and I am not quite sure why! Are there any other issues we need to pick up from the document?

PROFESSOR JANET HUSBAND: It may be a little premature, but I wondered whether we might put in here, “to explore opportunities in service accreditation in association with the Academy”, which is a subject that we have been discussing informally up till now, or whether it would be inappropriate to put it in at this stage.

THE PRESIDENT: I will leave Paul to comment on that, but there may well be good reason to comment on the work that we are doing with the Academy in general terms. Whether we get down to that specific issue is another matter.

PROFESSOR JANET HUSBAND: Yes, and other areas as well.

THE PRESIDENT: What do you think, Paul? Is it too specific?

MR PAUL BUCKLEY: We could certainly include a reference to the Academy project. Perhaps, outside of this room, myself, Janet and Amanda could talk about exactly what that might need to look like.

THE PRESIDENT: If there are no other points, we are simply asked to “endorse the approach and comment on”, and I think that we have probably done that. If you are content, we can move on to the next paper.