HOUSE OF COMMONS

Health Committee

Oral evidence: 2013 accountability hearing with General Medical Council, HC 897

Tuesday 10 December 2013

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Written evidence from witnesses:

- General Medical Council
- General Medical Council

Watch the meeting

Members present: David Tredinnick (Chair); Andrew George; Charlotte Leslie; Grahame M. Morris; Mr Virendra Sharma; Dr Sarah Wollaston

In the absence of the Chairman, David Tredinnick was called to the Chair

Questions 1-88

Witnesses: **Professor Sir Peter Rubin**, Chair, **Niall Dickson**, Chief Executive and Registrar, **Una Lane**, Director of Registration and Revalidation, and **His Honour David Pearl**, Chair of the Medical Practitioners, Tribunal Service, General Medical Council, gave evidence.

Q1 Chair: Ladies and gentlemen, I have been asked to chair this session in the absence of Stephen Dorrell, who is away on other health business. I would like to welcome you to this session. There may be Divisions this afternoon, so it may be disrupted. I would like you, if you would, to introduce yourselves, and then I understand that, Professor Sir Peter Rubin, you wish to make an introductory statement. Is that right?

Professor Sir Peter Rubin: That is correct, Chair.

Una Lane: Good afternoon everybody. My name is Una Lane. I am the director of registration and revalidation at the GMC.

Niall Dickson: I am Niall Dickson, chief executive of the GMC.

Professor Sir Peter Rubin: I am Peter Rubin, chair of the GMC.

His Honour David Pearl: I am David Pearl, chair of the Medical Practitioners Tribunal Service.

Professor Sir Peter Rubin: Perhaps I may make a brief introduction to bring the Committee up to speed with what has happened since we last appeared before you in September last year. As you will be aware, the GMC is the independent regulator of the medical profession, and our role is to protect the public by ensuring high standards of medical practice. We keep a register and currently there are about 250,000 doctors on it.

Since we last appeared we have introduced revalidation; we have opened a confidential helpline, which can be accessed by doctors who are finding it difficult to raise concerns in their place of work; we have published updated guidance on good medical practice and also, for the first time, guidance for patients on what they can expect from their doctor; and we have significantly influenced the next European medical directive.

Our work in revalidation, which is groundbreaking internationally, has attracted a lot of international attention, and a number of countries are looking and learning from what we are doing.

The last year has also seen, of course, the publication of very important reports—Francis, Berwick, Clwyd-Hart and Keogh—and we have been actively engaged in both giving evidence to those inquiries and responding to the recommendations.

With regard to revalidation, we intended to revalidate around 20,000 doctors in the first year, and we have done that. We have revalidated just under 25,000 doctors. It is still early days, but we are very confident that revalidation will lead to both an improvement in medical practice overall but also, very importantly, much earlier identification of doctors who have problems with their practice.

Our new employer liaison service is working well across the UK, with our employees working with medical directors to advise them both on revalidation but also, importantly, on performance issues with individual doctors and advice on what to do.

With regard to language testing of doctors from elsewhere in the EEA, we know this has been a matter of great interest to the Committee. I am pleased to report that an amendment to the Medical Act will be introduced in April 2014 to give us the power to test the English language of doctors from elsewhere in the EEA.

I mentioned just now that we had been active in influencing the next European directive. Very significantly, we have achieved an agreement that every regulator in the EEA will have a legal duty to tell every other regulator within three days if they remove a doctor from their register. This has not been the case before. The GMC tells every regulator in the world when we take action against a doctor's registration, and it is in the public domain on our website. That has not been the case elsewhere in the European Economic Area, and we are very pleased, as I am sure the Committee will be, that this will change with the new directive.

Very briefly, I have another couple of quick points. I mentioned the confidential helpline. We know that whistleblowing is difficult and that the track record of whistleblowers in the NHS is poor. We opened a confidential helpline a year ago this week, and we have had over 900 calls and initiated over 60 inquiries as a consequence of those calls.

In a national trainee survey we have begun asking trainees if they have concerns about patient safety; 5% did have concerns, and we followed up each and every one of those locally.

To end, again very briefly, last time the Committee urged us to speed up our fitness to practise processes and aim for a target of concluding 90% of cases within 12 months. We have achieved that. In the last 12 months we have concluded 92% of cases.

The Medical Practitioners Tribunal Service is up and running and now very well established. If there are any questions about that, Judge Pearl will be very pleased to answer them.

My very last comment is about the upcoming Law Commission Bill, which offers us great opportunities to achieve greater streamlining of processes that we have aspired to for some time. Thank you very much for your time.

Q2 Chair: Professor Sir Peter, thank you very much for that. I can let you know that we shall be asking questions on all of those points at some stage during the hearing.

At the 2012 accountability hearing the GMC told the Committee that it had intervened in a number of locations around the UK in the last year where it found that the standards of education and training had fallen below what it expected. What is the GMC doing to encourage registrants to highlight poor standards of care and raise concerns about the practice of their colleagues?

Niall Dickson: Obviously we recognise that this is an important area of work. As an organisation, we did recognise this before Francis, but that inquiry really highlighted it in a very major way. Before the last hearing, we issued new guidance both for mainstream doctors and for leaders within the medical profession about how they should both raise inquiries and respond to them. Over the last year we have been actively promoting that guidance. It is all very well producing guidance; it is another thing to get people to live by it, which was one of the challenges this Committee and others put to us around Mid Staffordshire, because it was clear that doctors were not following our guidance in raising concerns. Some did raise concerns but there was a culture within that institution of not raising concerns.

The question is: how do we go about trying to help this? Setting up the confidential helpline is important in two ways. First, it sends a signal to the profession that we are open to this and want to encourage it, but, secondly, it is also a vehicle whereby, as Sir Peter said, we have opened up more than 60 serious investigations as a result of doctors contacting us on that helpline. As Sir Peter touched on, we have also used the national training survey. Again, it is partly about collecting information from doctors about safety concerns, but it is also about sending a signal to them and indeed to the whole system that the raising of concerns by professionals is a routine and important part of professional life.

We have sticks in our bag, but an awful lot of what we have to do is to work alongside hospitals, employers and medical organisations in encouraging a change of culture. We know that, even within one hospital, it can vary. One team is quite easy and people can find it quite easy to raise concerns; in another it is much more difficult. The challenge for us going forward—and we are looking at this now—is about forming alliances at national level but also continuing our work at local level. We now have a small regional liaison team that comprises 12 to 14 individuals working at regional level. They are having meetings with doctors, groups of doctors, patient groups and others, and at the core of this is a conversation about how you challenge culture and enable people to feel that they are able to speak up.

Q3 Chair: That is very interesting; thank you for that. You have your confidential helpline, but if I am a registrant who is considering reporting concerns and making a complaint, what happens when I pick up the phone? How do I do this now, and why is the system improved?

Niall Dickson: If you are talking about referring to us, we have changed that as well. One of the reasons we are getting so many more complaints is that we have made it easier for

people to fill out the online complaint form. If someone phones up our call centre, we will help a patient, doctor or anybody else and take them through the process of making that complaint. The bigger challenge, frankly, is not so much how easy it is to get there when you contact us. We receive an awful lot of complaints—for example, from patients—that we are not able to deal with; in other words, they are not for us. As the Clywd-Hart report recognised, the system is still far too complicated and there are far too many variables at local level for people to find their way through the system.

The things that we can act on are at the more serious end. Most complaints and issues around doctors on a day-to-day basis should be dealt with effectively at local level. We have to make sure, first, that the route to us is absolutely clear and people can see that route, and, secondly, that people understand at local level that they can raise a concern without it affecting their career.

Q4 Chair: If it is too complicated, what exactly would you like to see changed? Can you be specific about the changes you would like to see occurring?

Niall Dickson: I am anxious not to step on others' toes, but one of the areas on which we are going to have discussions with NHS England is how you make sure that when a patient raises a concern there is an easy place for them to go to. For a long time there has been a lot of talk about creating a hub where individual complaints could go. We have said that we are happy to take part in those conversations, and we would certainly be happy to re-signal people towards that if they ended up in the wrong place with us. The challenge has always been that, if you create a hub, there is a danger of creating another ecumenical church, as it were; you create another place for people to go rather than where everybody goes. There is no doubt in my mind—Clwyd-Hart reflects this—that sorting this out at local level, making sure people know where to go as a first step and that it is effective is one of the biggest challenges. There are places that do it really well; there are others that do not.

Q5 Chair: You have touched on the Francis report, as did Sir Peter earlier on. Have you found that more registrants are contacting the GMC to highlight professional concerns since Francis?

Professor Sir Peter Rubin: We have seen a year-on-year increase in doctors referred to us by other doctors over the last five years. Niall will correct me if I am wrong, but I do not think there was a very obvious increase around Francis. It has been a five-year trend. Most striking for us is that, although complaints in general are going up, the potentially more serious complaints are those from doctors about other doctors.

Q6 Chair: Are you getting vexatious litigants as well? Is there a balance here?

Professor Sir Peter Rubin: We always get that, yes, and that is an inevitable consequence of any regulatory system; it is unavoidable.

Q7 Chair: If you have got that as well, there is a balance, is there not, so the number of real complaints may not necessarily have gone up?

Professor Sir Peter Rubin: The number of potentially serious complaints has gone up significantly over the last five years. They tend to be medical directors, for example, referring other doctors who are on the staff of their organisations.

Q8 Chair: Are these registrants more inclined to raise their concerns with the GMC than with their employers? If that is the case, is that because of the fear that employers will seek to discredit them?

Professor Sir Peter Rubin: I am not sure that we have hard data on that. We know there are concerns—this is getting a bit anecdotal—about how a complaint will be handled locally. We are seen as a more independent organisation that is more likely to handle a complaint in a straightforward manner. Whether or not that is the case is quite another matter.

Q9 Chair: But you have already highlighted that there is a problem of access here. You have said you are concerned that people should be aware of the route to come to you, so there is unfinished business there, is there not?

Professor Sir Peter Rubin: For those who are in the system—for example, a medical director—they know how to refer, and that is very straightforward. It is more challenging for a member of the public who may not know where to refer and the most appropriate level of referral.

Niall Dickson: One bit of evidence we do have is around the national training survey that Sir Peter mentioned. The fact that 5% of doctors are using the survey to raise their concerns and a significant number had not raised that concern locally indicates that there is still a challenge. If you talk, as we do, to groups of doctors in training, they will tell you that if you go into a team—I am not talking necessarily about anything major—the key point is that you should feel able to point out even the minor within that team. There is still a challenge culturally within medicine and other professions about feeling able, no matter where you are in the hierarchy, to raise that matter. We think that some of the people who phone up our confidential helpline simply want to say, "If I raise this, what will happen?" They just want a bit of assurance. They can read the guidance that tells them who to go to at local level and what steps to take, what to record and when to do it. All that is absolutely clear, but people just want assurance because when they do it it can feel very risky.

Professor Sir Peter Rubin: Can I just comment on the culture within an organisation? We are saying to trainees that we are interested in knowing whether they have concerns about patient care. It may be that they are not being asked. A good organisation will want to know if there are problems; they will want to be open and know these things. Maybe the fact we are asking means that we get the results we do.

Q10 Charlotte Leslie: To follow the points Sir David was making, do you recognise or acknowledge that sham peer review takes place?

Professor Sir Peter Rubin: What do you mean by "sham peer review"?

Charlotte Leslie: I was sent evidence of quite a serious allegation about two doctors living in my constituency. A doctor was interviewed by some managers, two of whom colluded in fabricating the minutes and so changed the contents of the minutes of the meeting, so this doctor was not able to speak out against the fabricated minutes of the meeting.

I want to ask a question about your confidential helpline. If a doctor raises a concern—blows the whistle, if you will—often the doctor who blows the whistle ends up being investigated.

The GMC goes to the medical trust director and says, "Is everything all right here?" and is told, "Everything's fine; there's nothing to see here. Who raised the concern?" The GMC names the doctor, and they say, "Oh, yes. Well, Dr So-and-so has some mental issues." Lo and behold, a little while later they get referred to the GMC on a personal thing—instability or inappropriate conduct. That is the story we have seen over the last decade. That is why I ask if you acknowledge that sham peer review exists.

Professor Sir Peter Rubin: I think we would need to see a bit more in the way of robust evidence.

Charlotte Leslie: So that is a sort of no.

Professor Sir Peter Rubin: I am saying we have to be evidence-based. Now that you have reminded me, I also saw the submission that you mentioned, and I had forgotten seeing it. In a case like that, we would be very interested in going in at a high level and inquiring of that organisation, without naming any names, "Can we look at your processes? Can we see how robust they are? Can we look at your record keeping?" This is what we do. We do a lot of investigation. If there are doctors who have concerns about this, we would like to know. That is one reason the confidential helpline is there.

Niall Dickson: In this kind of forum it is impossible to make a decision about who is telling the truth. As you can imagine, we get a lot of people claiming that the reason they are being referred is that they are being persecuted. We would absolutely take the view that because somebody is a medical director or holds authority in a hospital it does not mean they are right and the individual doctor is wrong. We should and do take an entirely neutral position as far as allegations made to us are concerned. Within the confines of what we are able to do, we try to the best of our ability to establish what has happened and, if necessary, put that to a panel, where sometimes it is argued out between both sides. In the course of human affairs you will get misuse of power by people in authority, which you are describing, but you will also get people who behave inappropriately and make allegations that are not true.

Q11 Charlotte Leslie: Given what we have seen of the treatment of those who have blown the whistle and the fact that most of them are still out of jobs, whereas those who have had the whistle blown against them and whose misconduct has been proved, particularly managers, for whom there is not a version of the GMC if they are not registered with it, tend to keep their jobs and get promotion, do you think the GMC has got the balance right between protecting whistleblowers and holding people accountable? Are you saying that you are happy with the balance that you have?

Niall Dickson: I do not think we are trying to achieve a balance quite as you are describing. I think we should look at each individual case and try to establish what the truth is in that case.

Q12 Charlotte Leslie: I am asking whether you are satisfied that the GMC has done that satisfactorily to date.

Niall Dickson: The answer is that it is impossible in one sense to tell because, at the end of that process, people are often dissatisfied; 50% of people who go through our system are by definition dissatisfied.

Q13 Charlotte Leslie: Are you satisfied that you have seen justice done to an acceptable level? There will always be dissent when there are two separate parties, but are you satisfied that the GMC has done its job correctly and as appropriately as possible, particularly given the history leading up to the Francis review and the treatment of whistleblowers that we have seen so far? Is that a record of which you are proud or which can be improved?

Professor Sir Peter Rubin: We introduced the confidential helpline because it became very clear, as I said in my opening statement, that the track record of whistleblowers in the NHS is awful. I think everyone in this room knows that. As Niall implies, we do get people claiming to be whistleblowers who are pursuing a personal agenda against their colleagues. On the other hand, through the confidential helpline we want to be an external organisation that can come in and shine a bright light on whatever is going on in a particular place.

Q14 Charlotte Leslie: When you say "confidential", will the trust in particular be notified of who the complainant is in that circumstance if it is confidential?

Niall Dickson: If we open a serious investigation, the law is clear. The complainant who is doing that will eventually have to give evidence against the other doctor, if it is of that nature. If a doctor does not want to give their name, it is very difficult for us. We can approach the trust and try to find out what it is about, but if we do not have that person's evidence to help us that can cause difficulty.

You asked a question about how confident we are and so forth. If I look at the staff who work for the GMC, I know that every one of them is trying their best to be fair in what they are attempting to do. They are not trying to be pro-doctor, pro-medical director or whatever. They are trained so that they are not biased in any way, and we have rigorous processes to try to make sure our system is the best. Could it be better? Of course it could, and we are constantly looking at ways in which we can make it faster, because there is a lot of pressure to try to speed up the process, but we also have to make sure it is as fair as it possibly can be to all those who are involved in what is inevitably, or quite inevitably, a traumatic experience.

Q15 Charlotte Leslie: If the Chair will indulge me, I would value a short answer because we have limited time. If one person has one set of evidence and that is presented to somebody else who has another set of evidence, will you share the counter-evidence with the person who provides the first set of evidence so that they can come back on it and challenge it? Do you share conflicting evidence? Is that part of the procedure?

Niall Dickson: Yes, it is.

Charlotte Leslie: You always share conflicting evidence.

Niall Dickson: Yes.

Charlotte Leslie: And then discuss it through.

Niall Dickson: Yes. The investigation will hear all the evidence, and then a doctor and senior lay member of staff—the decision makers are called case examiners—make a decision based on the evidence we have managed to gather about what the next stage is,

including referral to a panel, whether the case should be closed and so on. At the end of the investigation these two have to agree that that is the right decision.

Q16 Charlotte Leslie: I am being a bit slow. The first person says that x, y and z has happened; the second person says, no, no, no, a, b and c has happened. Do you then give the first person the conflicting evidence and say, "What do you say to that?", and they say, "They're wrong, because I can prove the claims they make are false because of this evidence"? Is that what you do?

Niall Dickson: Yes, though the actual experience sometimes is that the doctor who is facing allegations will be advised by their medical defence people to say not very much. That is something we are actively trying to change so that we have the full information when we are making that decision. At the moment, sometimes the doctor appears before the Medical Practitioners Tribunal Service, a rabbit comes out of a hat and they produce all this new stuff which we did not know about. We want to encourage people to share that before we reach the point where we are referring it to a panel.

Q17 Andrew George: As we are still at a broad-brush conceptual level, I want to ask all of you whether you feel we are now in a climate that is less tolerant of what I might describe as reasonable human error. Do you think that the medical profession is operating in a climate where we expect that they are humans and they will all make mistakes at some stage, but we are intolerant of any mistakes?

Professor Sir Peter Rubin: Can I have a go at answering that first of all? Medicine is a risky business. The very best doctors will be willing to take reasonable risks and will be very good at dealing with uncertainty. The worst thing we could do as a regulator would be to discourage doctors from taking reasonable risks understood by and shared with the patient, because so many people are alive today because doctors took reasonable risks.

In answer to your question, certainly over my professional career there has been a huge increase in the likelihood of a doctor having legal proceedings taken against them or being referred to the GMC. That is a consequence of the way the world around us is changing. It is very difficult, however, to get a real handle on whether that has changed the way doctors behave. Everyone will have a personal opinion and remember the golden era, but I am not so sure whether there really has been a change.

Q18 Andrew George: You are the professionals, and I am just asking the questions. Do you have any tools or forensic devices available to you that help you to distinguish between what I have described as the normal, reasonable expectation of human error and professional incompetence or malevolence?

Professor Sir Peter Rubin: We certainly do, and if a case is being progressed we would of course get expert opinion on what a reasonable doctor would have done under these circumstances. We are not here to pursue doctors who make an honest mistake in the heat of front-line practice; we are interested in protecting the public from recklessness. The two are quite different.

His Honour David Pearl: Perhaps I could develop that in one way. If a case is referred to the Medical Practitioners Tribunal Service for an adjudication, the first stage that is gone through is to make findings of fact. Once the tribunal has made a finding of fact, before it can impose any sanction, it needs to make a finding that that is both serious misconduct

and that as a result of it the doctor is impaired, so the question of impairment comes in. It is at that point that issues such as remediation, for example, very much take centre stage, and the panel is trained to consider just the sorts of issues you raise about how a reasonable doctor would have behaved when faced with that particular set of circumstances.

Q19 Andrew George: Do you use peer review? What benchmark do you use? I still cannot quite see how you measure with this kind of barometer or rule between human error and malevolence or incompetence.

Niall Dickson: Malevolence and incompetence are both pertinent. There is not a single bar for what is an acceptable medical standard. What you would expect of a surgeon of 15 years' experience is going to be different from what you would expect of somebody straight out of medical school. The way we measure the general practitioner, for example, is to get two general practitioners to look at that behaviour and say, "Is this within the bounds of competence?" Obviously, if it is misconduct, it is slightly easier to make a judgment about it, but, if it is a question of professional competence, we would use their peers to provide an analysis of whether or not it was reasonable.

Q20 Andrew George: When you do that, do you make sure that the peer review is nameless, for example, so that it is not coloured by knowing the person they are being asked to judge? In other words, if a person issued a "do not resuscitate" order in these circumstances—

Niall Dickson: They would not know the individual. It is not their mate down the corridor; we choose somebody entirely separate, so we do not do that.

Q21 Dr Wollaston: You mentioned that there were over 900 calls to the confidential helpline but only just over 60 serious inquiries. How much of that was because of anonymity? In other words, were you unable to progress what you considered to be a serious complaint because the doctors concerned refused to give evidence on a named basis?

Niall Dickson: We will be producing a report on all the calls, but my understanding as of now, having talked to some of the people who are on that helpline, is that quite a lot of those who phone are not saying, "I want you to open an investigation into a doctor." They are saying, "I'm in this position. I was thinking of doing this. Is that the right thing? To whom should I talk? Should I talk to the Royal College? Can you clarify a piece of your guidance?" There is a range of things that they will raise. The cases that we have opened are ones where they are making a serious allegation about another doctor and their behaviour, and that is why we have opened up the investigation.

Q22 Dr Wollaston: The point about anonymity is important. I know that the GMC takes this seriously. For example, on social media, you have said you do not think that doctors should be tweeting or using Facebook as doctors unless they are prepared to say who they are—and I think with good reason. But on the point about anonymity, do you feel there is a danger that some doctors are putting their own careers before protecting patients by being prepared to put their name to an actual complaint? How often do you think that is happening?

Niall Dickson: I am not sure what proportion of doctors—we will do this when we publish the results of the confidential helpline—are saying, "I don't want my name mentioned."

Some will not give their names because the conversation is quite short and they say, "I just want to check up," and that kind of stuff.

Dr Wollaston: I understand that; it is just a quick check-up. I am talking about the serious complaints.

Niall Dickson: To be honest, I do not know what percentage of those are saying, "I don't want my name used. I want you to check up on this hospital because I'm so frightened." But we will publish the data on that.

Professor Sir Peter Rubin: It is a really important point, and you are making the same point to us. We wanted to make a helpful move by opening the confidential helpline, and we have done that; it has been going for a year. You are both making really important points, to which we cannot give you a straight answer at the moment, but we recognise the importance. We want to ensure that we know about issues where patient safety information is being suppressed locally. That is what the confidential helpline is for. If we have not got it right, or if we can do things to make it easier for a doctor to progress a complaint, we will learn from the analysis, and we have taken on board the points you are both making.

Q23 Charlotte Leslie: I know that the group Patients First, which has been supporting whistleblowers, indicated in its evidence to us that it was rather disappointed that the GMC had not taken up its recommendations and held a meeting, or its offer to work in partnership to see how the GMC could better support whistleblowers, particularly in view of the tragic incidence of suicides and deaths of doctors under fitness to practise and the fact that blowing the whistle can be very traumatic and stressful if somebody's job is at stake, which is all too often the case. Will you be meeting Patients First and taking up its offer to look at some of its recommendations and experience of working with whistleblowers—not that you are in the stocks for anything?

Niall Dickson: We have had a number of meetings with Kim Holt and her colleagues. The door is always open, and we will have discussions. You mentioned the slightly separate but very important issue about doctors who commit suicide under our procedures. You will be aware—it is in our evidence—that, independent of any external pressure, we have set up a review to look at doctors who have taken their own lives within our procedures.

The reality is that many doctors, when they are referred to us, particularly under the health procedures, are suffering from quite serious mental health conditions. The process itself, as everybody recognises, can be very traumatic. We have already taken a quite significant number of steps to try to make it less traumatic for them. Any doctor within our health procedures has a workplace supervisor, who is another doctor. They are seen by two treating psychiatrists on behalf of the GMC, so we do take seriously our responsibilities—our duty of care, as it were. Over recent years we have ordered what we call a significant event review, which is the equivalent in the health service of a serious untoward incident, every time there is a death so that we try to learn the lessons from that.

Our feeling was that there was a danger that you would just do that and say, "We did everything we could" and so on. We wanted to see if we could dig down a bit deeper to understand whether there was any more we could do. We now have a contract with Doctors for Doctors, which is the BMA support service. We offer that to all doctors who are part of

our procedures. We have introduced a witness support programme that supports witnesses who are appearing both on behalf of the GMC but also on behalf of doctors. We have done some research with doctors who have been through our procedures about what it was like for them and so on, and we are about to do more work. We have had meetings with the practitioner programme on which Clare Gerada works. We have worked closely with them on redesigning some of our materials.

So we absolutely take this really seriously to see if there is anything we can do. We have to pursue patient safety. That is what you set us up to do; that has to be our first concern; but we recognise that often we are dealing with people who are in a very unhappy place even before they are referred to us.

One other comment made by somebody from that programme is that they have met doctors who have said, "The GMC saved my life. Being referred in was a good thing because it meant I was able to alter it." But we also recognise that what we do causes additional trauma, and we must do everything we can to try to deal with it.

Q24 Chair: Do you run a suicide risk assessment on occasion?

Niall Dickson: There is an assessment by the two psychiatrists and the workplace-based supervisor, and they do highlight that. One of the things we are looking at through the significant event review is whether anybody was saying of these doctors, who were overseeing and looking after these patients, as well as the doctors' treating psychiatrists—they frequently have that as well—that there were any signs that we could have done anything. Obviously, we are not in the local area when that is going on. All these people—the workplace supervisor, the treating psychiatrist and our two psychiatrists—are doing that, and, if any of our staff become aware of any issue where, for example, the doctor says, "I'm going to take my own life," that would be an immediate trigger for us to do something; but a lot of the individuals who commit suicide are people in respect of whom we know there was a high risk—absolutely. That is the reality that people who work in mental health services face all the time.

Q25 Dr Wollaston: I just wonder about changing the culture around complaints. Do you think there is a role for the GMC in educating the public that an organisation with a higher number of complaints might be a good one because it has an open culture in dealing with complaints? What could the GMC do to promote that?

Niall Dickson: We do have a role there. Educating the public is a big task for an organisation like ours.

Dr Wollaston: It is probably the wrong phrase, but you know what I mean.

Niall Dickson: I absolutely know what you mean. One of the things we can do and will do is that we are about to publish rates of referrals from individual trusts, so we are trying to expose all this data that we have had operationally for years but have never had the ability to section off and make sure is robust. The commentary we put on that is that a lot of referrals from a place does not mean it is bad; indeed, it could mean that its clinical governance arrangements, which are absolutely crucial for revalidation, are really rather good and they are able to do that, whereas with regard to somewhere where nothing is happening you might say, "Are they doing the job?" We have to put a caveat around all

the figures that we are starting to put out. By putting out the figures, I hope we will start to have a grown-up debate about this.

Una Lane: I endorse what Niall has said. On the one hand, where we see in some organisations a significant number of referrals to us from medical directors or other senior doctors, or a significant number of complaints, we may have the data, but the intelligence that sits behind it is probably something we do not have. It could mean that this is a good organisation that takes its responsibilities seriously around patient safety and care, making sure they are acting very swiftly in relation to individual doctors where there is cause for concern. On the other hand, it could mean that it is an organisation that is not taking its responsibility to deal with these matters locally as seriously as it should and is not responding adequately to patients who are raising issues with it. We are beginning to analyse and publish that data, but it is the beginning of a conversation around that and the beginning of an understanding of whether this can lead to genuine intelligence about these organisations rather than simply data which in and of themselves could mean a number of things.

Q26 Chair: We are going to be moving on to revalidation in a moment, but before we do I want to ask a couple of questions about emergency care and patient safety. The Health Committee produced a report in July in which we said that trainees and consultants alike found working in emergency medicine to be relentless and demoralising. Do the findings of your survey of doctors in training support this description?

Niall Dickson: Yes, they do. Ours is a limited survey. We dipped into a number of trusts where we thought there might be some difficulties. We also, incidentally, went to two that were very good, because we think you can learn as much from places that do it well as those that are doing it badly. We have concerns. Recruitment in these areas is difficult; the experience of doctors in some of those trusts suggested that the pressures they felt were excessive.

Q27 Chair: Turning to patient safety, you have said that one in 20 doctors in training have reported concerns connected with patient safety. Have you made an assessment of the proportion of these complaints that relate to emergency medicine?

Niall Dickson: I cannot give you an answer, and we will send a note to the Committee, but the answer is that one of the areas from the national training survey, for example, has been a concern about obstetrics and gynaecology and some of the relationships between professionals in that area. As a result of that, we will be doing another set of checks in obs and gynae next year. One of the great advantages of the national training survey is that it gives you that kind of information. We will send you the detail in relation to emergency medicine.

Q28 Andrew George: One would anticipate a higher number of errors being made if you put people under impossible pressure and stress. In those circumstances, bearing in mind the example of the emergency departments and the pressures under which they sometimes find themselves, if you are identifying this as a trend and an area where errors are sometimes regrettably made, how do you engage with that and communicate any findings from it? As I understand it, it is your role to look at individual cases of individual professional competence to do the job, whereas it may well be that there is a systematic or resource issue that needs to be fed back and lessons learned, both at the individual hospital level but perhaps also in the

health system or even at the political level. Do you see your role as ensuring that those lessons are learned, not necessarily by the individual doctor but by the system, the hospital and so on?

Professor Sir Peter Rubin: The answer is yes. You are quite right that we have a statutory duty to regulate individual doctors. Over the last few years, at least since Niall and I have been at the helm of the GMC, we have extended what we do quite widely. We have commissioned research and done the kind of surveys that you have been hearing about. We share the results of that very openly; it is all in the public domain. We see trends that will be of huge importance to NHS England and other organisations like that. I think we have a major role to play. We will soon be one of the few areas of health, or possibly the only one, that has a UK-wide perspective.

Q29 Andrew George: You say you have a major role to play. Do you play it?

Professor Sir Peter Rubin: Yes, absolutely.

Q30 Andrew George: In other words, do you communicate it, and how do you communicate it? Do you communicate it to Health Ministers?

Niall Dickson: We do communicate it to Health Ministers. The other point to make is that we are an individual regulator, but we are also a system regulator in relation to education. Indeed, this is an education responsibility, so, if you take the national training survey, it is not just a question of asking every doctor to write something down. This is fed back to every single local organisation. The deaneries then have to respond about what they are doing in their area and how they are dealing with it. They use this, and they see individual departments where they have difficulties. It is quite a fine and useful tool for people at local level to reflect on the kinds of pressures they are in.

The big change over the last year is in the system regulators. If you ask the CQC and Monitor, they will say that the national training survey is one of the most important measures of what is happening in hospitals. It has changed the behaviour of the CQC, which, when it makes inspections, now talks to groups of junior doctors and doctors in training. We have had that influence, and we will continue to do it.

As to the obs and gynae stuff, we will work with the Royal College and, once we have done those checks, we will absolutely draw it to the attention of Ministers and NHS England, but actually we can also talk to people at local level. We have the power in theory to withdraw trainees. If we find that there are difficulties in those areas, we will have robust conversations with those organisations.

Q31 Andrew George: Is it your role to go one step further and make recommendations on skill mixes within a particular setting—not only in the training setting where you have trainees in an emergency department, for example—and to specify that at a certain level of throughput of patients of a certain acuity, you should have this number of grades of doctors on site? Or is that beyond your responsibility? Should you leave it to another body, whether it is the Royal College or others?

Chair: Perhaps you would answer this question, but there is a Division in the Commons, and the Committee will adjourn for as long as it takes for us to vote and come back.

Professor Sir Peter Rubin: At one level, it is beyond our responsibility. However, in certain hospitals we have withdrawn approval for training in A and E departments, for example, because the environment is wrong. Indirectly, we have a massive impact. Once we do that, it really gets people to take notice of what is happening, so indirectly, yes, we do that.

Chair: We have one question from Charlotte Leslie and one from Dr Wollaston afterwards on this subject and then we are going to move on to revalidation.

Sitting suspended for a Division in the House.

On resuming—

Chair: If Sarah and Charlotte would like to ask questions following on from that last session, they can do so. Grahame Morris, over to you.

Q32 Grahame M. Morris: I apologise for slipping out earlier. I was presenting a petition. I want to raise specific issues in relation to revalidation. I, and perhaps the Committee, would like better to understand the role and relationship of the responsible officer. Perhaps I might start by asking Una and Niall, and maybe Professor Rubin as well, about the introduction of revalidation, and whether it has identified more failings in the practice of doctors compared with the old employer-led system. Is it your opinion that it has been able to pick up more failings in practice?

Professor Sir Peter Rubin: We do not have robust evidence to back this up. When responding to the Chair earlier, I said that the number of referrals from medical directors has gone up significantly year on year. My personal view is that revalidation had a major impact before it even started, because effective systems of appraisal and so on were introduced in hospitals and identified people who needed to be referred. I think the impact antedated the introduction of revalidation by maybe three or four years.

Grahame M. Morris: Do you have a view on this, Una Lane?

Una Lane: In terms of revalidation more generally, it is 12 months since we kicked off revalidation on 3 December. In some ways, given what Peter has said, certainly we have seen an increase in referrals to us, but in many other ways it is early days. It is going to be another two years before the vast majority of doctors are revalidated, and a further four years before all the remaining trainees are put through the process.

There is significant evidence that all health care organisations are now taking some of their local responsibilities more seriously. We see many more doctors who are subject to appraisal than was the case a number of years ago. We see many more organisations that now have policies in place to identify poor performance at an earlier point in the process, and indeed have processes in place to help the reskilling, rehabilitation and remediation of doctors locally. There is some evidence thus far that revalidation, in both its planning and introduction, is making a change, but by this time next year, when we come back before the Committee, hopefully we will have more robust, hard evidence about what is happening on the ground.

Q33 Grahame M. Morris: Is it fair to conclude from those replies that there were failings in the old system?

Niall Dickson: Yes, there were. We have introduced an attempt to encourage and put in place clinical governance arrangements that the health service said it had done about 10 years ago. The answer is that revalidation has acted as a significant catalyst both in terms of procedures but also as an awakening within the boards of hospitals and so on about their responsibility for ensuring the quality of the medical staff who work for them. That is a very basic responsibility, and revalidation is a wake-up call. It is still a wake-up call; we are not saying we are anywhere near the end. It is cultural change at local level that, in a way, is more important than the ticks that come through to us every five years. It is setting in place stuff at local level. You can talk to people at local level, and certainly our feedback from responsible officers is that this is a significant change.

Q34 Grahame M. Morris: That leads me to my next question about the responsible officer. I would like to try to understand the relationship or link between responsible officers and employee liaison officers. In terms of the numbers, is it the case that the local area teams of NHS England appoint only one responsible officer—I think there are 16 local area teams—to oversee the revalidation of GPs in their particular area?

Una Lane: Shall I kick off on the role of the responsible officer? It is a relatively recent role and was introduced in regulations across the UK in January 2011. It is important to remember that responsible officers are not creatures of the GMC. In many ways, their role existed already in health care organisations across the country. It was mainly a medical director role. The responsible officer's role became a statutory one in an organisation, which effectively had been performed previously by a medical director.

The important thing about the role of the responsible officer is that the regulations that brought responsible officers into being place duties on organisations. They place a range of statutory duties on organisations to evaluate the fitness to practise of doctors; ensure that doctors have an appraisal; and ensure that they have proper and robust clinical governance systems in place. The role of the responsible officer is effectively to be accountable for delivering the organisation's duties in that respect.

As to numbers, there are over 800 organisations across the four countries in the UK that are designated—in other words, subject to these statutory duties. Therefore, we have over 800 responsible officers in total.

In relation to the restructuring of NHS England, we moved from having 10 strategic health authorities and over 150 primary care trusts—Sarah probably knows better than I do—to a situation where we now have four regional teams or sectors of NHS England and 27 local area teams. You are absolutely right that for GPs in England there would be one responsible officer in each of those local area teams, who is responsible not only for making revalidation recommendations to us but also for fulfilling all the statutory duties I mentioned a moment ago.

Q35 Grahame M. Morris: Do you think the ratio is sufficient? At the very start of your evidence you quoted the numbers. Obviously, there is a proportion overseas who are on the register. That is a relatively small number of responsible officers not just for revalidation but to oversee general professional standards. In your opinion is that enough?

Una Lane: The way I tend to look at the role of the responsible officer is that it is a function rather than an individual. I often compare it with chief executives of organisations. Niall is the chief executive of our organisation. We have 1,000 staff and contract with a further 1,500 people. It is about the resources that an individual has in place to support their function. It is not simply a numbers game; it is much more about whether the area teams provide the right and relevant resources to support responsible officers in delivering the statutory duties that fall on these organisations. That is probably a roundabout way of saying that it is about resources provided to the individual rather than necessarily simply about the numbers.

Q36 Grahame M. Morris: What sort of feedback has there been from doctors about the performance of responsible officers and their capacity to provide the support and oversight required to be effective? Do you have any information on that?

Una Lane: Again, looking particularly at NHS England, there is no doubt that the restructuring presented some challenges. When we began revalidation back in December 2012, we had strategic health authorities and primary care trusts. Come 1 April, they disappeared and we had a whole range of new organisations that needed to take up the reins fairly swiftly. Peter probably knows a little better than I do and may be closer to it. Like everything else, the views of doctors are mixed. Some have very positive views about their experiences of appraisal and responsible officers locally; others have a slightly more negative view. I do not think there is a uniform or consistent view.

Q37 Grahame M. Morris: Do you measure that, or is that just anecdotal?

Una Lane: As part of the work that we do more generally at the GMC, we develop what we call tracking surveys with individual doctors and others. We have very close relationships with responsible officers, but one of the things we want to track over the next number of years is exactly the areas that you are covering: how individual doctors are experiencing this locally, and what their experience is of the role of the responsible officer and appraisal. We are also developing what we call an evaluation framework. We are working very closely with an academic partner to try to evaluate better what we cannot see at national level to understand what is happening locally on the ground.

Niall Dickson: The profession's views have probably changed over the last few years. Even three or four years ago there was a feeling that revalidation would never come. They had waited an awfully long time for it. There was probably a period when people said, "Oh, really; it is going to arrive," and that would cause some antibodies among some. The impression you get is that the profession has now accepted that it is inevitable because it is here, and, as more and more people go through it and they are still alive at the other end of the process, some of the fear about it will also be overcome, but we have to see. We have said that we will adapt it as we develop and understand what the right model is.

Professor Sir Peter Rubin: Leading up to revalidation, there was a lot of noise in the medical press about it. The world was about to end, basically. Here we are a year on with nearly 25,000 doctors having been revalidated. That noise has gone. People have been revalidated; the world has not ended; they have survived the process. It has been accepted, as Niall said, that it is here and is working.

Q38 Grahame M. Morris: Perhaps you could explain again for my benefit and that of the Committee the relationship between employee liaison officers and the responsible officer. I also want to know about the growth in the number of organisations producing formal remediation policies. Una Lane mentioned the number. Did you say there were 800 such organisations? Is it correct that the responsible officer is also responsible for working through low-level complaints and remediation with particular doctors? Could you elaborate on that?

Una Lane: Perhaps I could talk very briefly about responsible officers dealing with what may be complex but low-level complaints that do not require referral to the GMC, and whether they have processes in place to do that.

Grahame M. Morris: Are informal policies rather than informal procedures important?

Una Lane: That is absolutely right. I mentioned a moment ago that all of these organisations have a statutory duty to evaluate their doctors, and make sure they have systems in place to identify emerging poor performance before it gets to the point of becoming an issue of patient safety or quality of care. If you look at some of the surveys that have been done with organisations over the last number of years, about half these organisations—even back in 2011—did not have formal processes and policies in place to deal with remediation, rehabilitation and reskilling in circumstances where they had identified emerging poor performance.

The most recent survey completed in England indicates that in the region of 85% of these organisations now have those formal procedures and policies in place. Again, we think that the introduction of revalidation has acted as something of a catalyst and driver to ensure that organisations are doing effectively what they should have been doing in any event. From where we are sitting, the introduction of the role of the responsible officer has made a significant difference in addressing issues that should probably have been addressed before now.

Q39 Grahame M. Morris: In terms of formalising the process, are the employee liaison officers responsible for overseeing the responsible officers' work? Obviously, there are a lot more responsible officers. Is that part of the lines of accountability, or do they work alongside and support them?

Niall Dickson: No. The employment liaison advisers—the word "advisers" is important here—are employees of the GMC. Their job is to advise responsible officers on their—the responsible officers'—statutory responsibility. There is no accountability line between a responsible officer and employment liaison adviser, but a responsible officer does have three accountability lines. First, they have an accountability line within their own organisation to the designated body that Una has described, which is responsible in terms of the regulations. Secondly, they have a responsibility—I guess you eventually reach the Almighty—to their responsible officer; they are accountable to their responsible officer. The third line of accountability is that, like any doctor, they have accountability to the GMC. There are three slightly different strings at work here.

The employment liaison adviser is there as a supporter and adviser. Of course, if an employment liaison adviser was concerned about the clinical governance arrangements within a trust and about what was happening, they would alert their manager within the GMC, and we would take the necessary steps, going back to the trust itself and the

responsible officer of that responsible officer, or, if it related to the actions of that individual and we could take steps, we would do so; but they are not there to supervise responsible officers.

Q40 Grahame M. Morris: Has the kind of scenario that you have identified, where an ELO has concerns about the performance of a responsible officer and he could notify the GMC, or take action with the employer, happened in practice, or is it just a theory? Is there evidence that that has happened—for example, where the responsible officer is being too lenient in his revalidation procedures?

Una Lane: There are two points I would make about that. First, it is probably quite early days yet. Secondly, we have had experience of very small organisations that are designated bodies. When we talk about organisations, sometimes we think of significant hospital trusts, training hospitals, local area teams and GPs, but a number of these bodies are small independent organisations. We have had examples where one individual responsible officer seems to be the responsible officer for a range of organisations. That is not necessarily inappropriate or improper, but in those circumstances we have had conversations with that responsible officer's responsible officer at regional sector level, and we begin to probe issues such as that to begin to understand whether there is a genuine difficulty that we would need to address. It is probably slightly early days yet. We have not had any significant concerns raised about responsible officers in relation to the larger NHS organisations, but no doubt that time will come.

Grahame M. Morris: You have not had any as yet.

Una Lane: Not as yet.

Grahame M. Morris: That is interesting; thanks.

Q41 Mr Sharma: My question is about patient feedback. The Committee's last report concluded that the five-year basis was insufficiently challenging. In your evidence you say that you are keeping this under review and working with patient groups. What more do you plan to do to feed patient feedback into the appraisal and revalidation process?

Una Lane: Again, it is fair to say that this is the beginning of a process for us. It is a genuinely big prize to see revalidation driving every single licensed doctor to seek feedback from patients periodically. If you look at some of the surveys in relation to health care organisations that were doing this routinely over the last number of years, in 2011 only 25% of organisations providing health care to patients in the UK had processes in place to ensure that their doctors could seek feedback from their patients in a structured way and act on that. If you look at the most recent survey in England, over 90% of organisations now have such structures in place. We think we have set a base level where we believe that every doctor must periodically seek feedback from patients, but we absolutely agree with the Committee's conclusions last year as well. We cannot stop here. Our view is that it is not simply a matter of moving from once every five years to twice every five years, and that will be fine and everybody will be happy. We need to get much more sophisticated about how we engage with patients on this particular issue.

Some of the early work we have been doing with both doctors and patients is that structured feedback is all very fine, but both sides very often want a proper dialogue. Patients

want to be involved more generally with the practice or care that has been provided in their organisations. We had a seminar with patient groups in October, which came up with a range of suggestions about how patients could be involved in the review of significant events—for example, reviewing complaints raised by patients and organisations—and we are beginning to explore, although we are just on the threshold, how we can use things like social media or link in with friends and family tests.

We are completely with the Committee on this. It is very important that every doctor seeks feedback from patients. We are making some progress on that, and we expect every doctor to be part of that structured process over the next number of years, but we want to explore much more widely and broadly how we can be more imaginative, become more sophisticated about it and work with others to ensure that patients have a genuine, proper voice in the evaluation of their doctors.

Niall Dickson: It is worth adding that, as well as the structured feedback that we require once every five years, we require doctors, as part of the supporting information they bring to their annual appraisal, to include all compliments and complaints they have had over that period. It should be an ongoing part of it. I suspect we are in the early days of a revolution in how patient feedback is fed to professionals. The digital revolution is driving a lot of this and making it a lot easier. We have set up a system; we are trying it out and it will change. We will develop it and listen to what patients and patient groups say.

Chair: Before we go on to fitness to practise, I would like to go back to professional obligations, as Dr Wollaston and Charlotte Leslie had a question on that.

Q42 Dr Wollaston: I have a question about your role in medical education and work force recruitment in crisis areas. We have touched on A and E and obstetrics and gynaecology, but there is also a real work force shortfall in primary care. Do you feel that a lot of this goes back further than doctors after graduation—back to medical school—in the emphasis on, say, primary care and education around A and E within medical schools themselves? How much do you feel that feeds into the work force problem?

Professor Sir Peter Rubin: My personal view is that if a student is not exposed to enthusiastic role models they are unlikely to go into a particular area. I did what I did because of role models, not because of some textbook. So there is that element to it.

There are also more complex issues about lifestyle, how people want to practise and so on. You need good role models and you need medical students, including the foundation programme, to be exposed to all the good bits of A and E and primary care. In the right environment, A and E can be such good fun, because it is front-line medicine; you are dealing with acutely ill people and you can change their lives. If you have role models who really enjoy that, you can have a big change in recruitment. Equally, once recruited, you and I both know that you have to make sure that the environment is right. If you are just drowning under a torrent of new patients coming through the door and feel you are practising bad medicine, you want to do something else.

Q43 Dr Wollaston: Except, of course, that as the GMC, your role is in shaping the medical curriculum. Do you feel you have a role in placing more emphasis on the curriculum in those areas? I accept your point about role models, but do you think there is also a curriculum deficit?

Professor Sir Peter Rubin: Having been around the GMC and in education for a long time, my view is that it is now the case that all medical schools have a lot of primary care in their curriculum. For example, in my medical school the first doctors that the students meet in the first two years are all GPs, so there is already a lot of it there. The look on your face suggests that you do not agree.

Q44 Dr Wollaston: It is hugely variable across medical schools, is it not?

Professor Sir Peter Rubin: It is variable.

Q45 Dr Wollaston: Have you established any link between the amount of time spent on the curriculum and the percentages of qualified doctors from those medical schools that go into different branches of medicine? Are you aware of any correlation?

Professor Sir Peter Rubin: I am sure it has been studied. I cannot give you an answer this afternoon, but we will see what we can find on that.

Niall Dickson: We are looking at reviewing "Tomorrow's Doctors", published in 2009. We do not devise the curriculum, but we demand the outcomes of undergraduate medical education. We are inevitably hearing lots of voices saying, "We want more of this and less of that" and so on. That will be part of the review we make of "Tomorrow's Doctors", which was introduced in 2009.

Chair: I would just alert you to the fact that we had discussion about this earlier on. I am going to return to the issue of doctor training and how it fits into the post-Health and Social Care Act paradigm of health with particular reference to patient choice, which is a central issue.

Q46 Charlotte Leslie: How do you assess the quality of medical training for doctors from eastern European countries? Is it correct that you have just changed the status of Poland?

Niall Dickson: We do not assess the training of doctors. We are bound by European law. Doctors from the European Economic Area have a right to come into this country if their qualification is recognised under European law. We would argue that it is a weakness in our regulatory defences, and that is why, on the language side, we have made such a noise about trying to get that changed. As far as medical schools in other parts of Europe are concerned, we are not able to do that, and the new directive does not do so. The system we have just described of responsible officers and so on means that when these doctors come to this country they will have to get a responsible officer. That responsible officer will have a duty to ensure that doctors are competent to do the jobs they are doing, and that they have the language skills to be able to perform.

Q47 Charlotte Leslie: I am sorry to interrupt, but we have such little time. When Bulgarian and Romanian doctors are able to come over in the new year, will it be possible for a doctor to come over for 18 months' work without being revalidated and going through that process and then go back home again?

Niall Dickson: Just to be clear, I don't think there is anything new. They already come now; that does not change.

Una Lane: Since 2007 Bulgarian and Romanian doctors have been able to travel to the UK, and we are and have been required to register and license those doctors if the degree from their medical school appears in the European directive. That has been the case for a number of years. Every single doctor who is registered and licensed with us is subject to revalidation. The point we try to emphasise on revalidation is that it is not a point-in-time assessment. The whole idea of revalidation is that it is meant to be a continuous evaluation of the doctor's practice in the workplace. Every doctor from the EEA who comes to work here in the UK must connect to a designated organisation and a responsible officer, and must maintain a portfolio of information and bring that to appraisal on an annual basis to support their revalidation. It is technically possible that, 18 months down the line, they decide to leave the UK, relinquish and give up their licence, and therefore might not ultimately revalidate at a point in time. So, yes, that is possible.

Q48 Charlotte Leslie: I have a quick observation, going off at a slightly different tangent, about the training survey that you have undertaken. In some ways, does it not feel, from yours and Sir Peter's point of view, a bit like a return to the past? Pre-2003, there were hospital recognition committees and specialist commissioning boards from the royal colleges. They went round and did not do just a paper survey of trainees but interviewed them confidentially, and lots of problems were raised if there was an issue with a senior consultant. It was a very rigorous way of doing it and was more than just a paper survey. When the PMETB was introduced—and you, Sir Peter, were on the board of that—that kind of did away with that. In some ways, does it not feel like a back-to-the-future system and like we are reinventing something we scrapped in the early 2000s?

Professor Sir Peter Rubin: At its best, the college visiting system was very good; at its worst, it was unhelpful. The problem was that there was such a wide spectrum in the quality of the college visits. For those who do not know, I was the chairman of this organisation PMETB—the Postgraduate Medical Education Training Board. In the year before PMETB was established, there were over 1,100 individual visits by colleges to training locations, and the quality of the information provided by those visits was incredibly variable. That was the problem. We would argue that the national trainee survey, which was begun by PMETB and is now far more sophisticated at the GMC, gives a much more robust view of training across the UK. With 50,000 trainees, a 95% or 96% response rate and a lot of granularity in the questions, we think this is a much more powerful system, particularly when we can then follow up issues that need to be pursued.

Charlotte Leslie: It was just an observation.

Q49 Dr Wollaston: We understand from your evidence that there have been 8,109 complaints from the public to the GMC in 2012, which is a 24% increase on the previous year. You also said that you are undertaking research to understand why this increase is continuing. Are you able to share any of the interim findings of that research with the Committee today?

Niall Dickson: I cannot share or confirm it because we are just initiating it now, but we have done earlier research. We are trying to understand more about the public. We have talked a little about understanding what is happening within the health care world and why you might get more in that sense. The only thing you can say about the evidence is that we are not unusual. Other professions, including health care professions, have seen similar

increases. Nor are we alone in national terms. You will see similar increases in developed countries in other parts of the world. I do not think anything strange is happening in the UK.

Why is it happening? The obvious point is that patients are less deferential; they are more questioning of professionals, not accepting necessarily what they say; they have more access to information than they ever had. Therefore, the asymmetry of information between professional and patient has begun to change.

The technology itself is quite interesting and is not something we had really thought about. In order to make a complaint to the Singapore Medical Council you have to get a public notary to sign it off. The speed with which you are able to do that and how easy you find it to complain is a factor. In the past, you would have had to write a letter to the GMC and put it in an envelope; now you can go online and quite easily fill in a form. If you phone our contact centre, the staff will help take you through it if you have any difficulty. There is something about ease of access to raising complaints as well, but we may find other reasons that I have not mentioned.

Q50 Chair: On the point about patients being more demanding and having more choice, there are also patients who now get very worried about the side effects of drugs. The Science and Technology Committee, of which I am also a member, is looking at antimicrobial resistance and problems with antibiotics. Wearing the hat of the chair of the All-Party Group on Integrated Healthcare, many people now go alternative medicine because they are concerned about some of the side effects of drugs. They will turn to herbal or homeopathic medicine because they do not want to go down that route. We have to recognise that the winds of change, to paraphrase Macmillan, are blowing through health as they blew through Africa. Surely, we have to recognise that, if we are to give patients choice, we have to listen to what they are asking for.

Professor Sir Peter Rubin: Perhaps I could answer that as a doctor. I agree with you 100%. I was involved in high blood pressure for many years. For example, in my high blood pressure clinic, in randomised controlled clinical trials, a sizeable percentage of patients taking placebo tablets found that their blood pressure went down. My pragmatic view is that, if it works, great; blood pressure has gone down. If alternative therapy or homeopathy—or the two combined with conventional therapy—work, my very pragmatic view, which I have held for many years, is that that is what the patient wants; they want their blood pressure to go down, their anxiety to be relieved or whatever. So I absolutely agree with you.

Chair: On that very point, the university of Bordeaux published a study called "EP13", which shows that, among the 40,000 French doctors who practise homeopathy, where they have combined homeopathy with conventional medicine, the costs of treatment and the amount of conventional drugs prescribed have gone down, but patient satisfaction has gone up. I really do not want to dwell on this, and it would be out of order to do so. Well, it would probably not be out of order because I am chairing the Committee, but I am not going down this route. But there are things happening out there. We have to be alert to these new studies and, if not act on them, at least recognise that they are valid.

Q51 Charlotte Leslie: In looking at the GMC's decisions on fitness to practise and, I suppose, public trust in its ability to judge cases, which is important for doctors coming

forward, I want to turn to a specific case, but only to illustrate issues within the GMC about which doctors and the public feel suspicious. If I talk about a specific case, it is to illustrate a wider point.

You might not be surprised to learn that the case I want to talk about is that of Barbara Hakin. The reason it is important is because it is a very symbolic case. Is the GMC on the side of the establishment and very senior people in management who happen to be clinicians as well, or is it on the side of the whistleblower—the disruptive influence, if you like? One thing of concern to the public is that the GMC judgment on Barbara Hakin seemed so counter-intuitive to the evidence that the GMC received. In many cases it seems that Barbara Hakin's account was taken over the evidence received that something was wrong in Lincolnshire and that extra capacity was needed.

I know you have said that patient safety and targets are the same, but the code of conduct recommends a capacity review because it is acknowledged that they are not always the same. It was said that safety was fine in July 2009, but that was not the period over which safety was being talked about. We have seen the handwritten note from Barbara Hakin talking about putting targets ahead of demand. To the lay person looking on, given all these things, it looks very much like the GMC has supported one of its most senior members against all the evidence.

Niall, earlier you said that the GMC shares conflicting evidence—evidence that seems to contradict the initial evidence. Those who give the initial evidence have a chance to refute it and say why the contradicting evidence is not true. This does not seem to have happened in this case, because many refutations could have been made to Barbara Hakin's evidence. What is your response to that? I am afraid that in that case it does not seem that the GMC performed its role and was impartial.

> ***Niall Dickson***: The first point to make is that Barbara Hakin is not a member of the General Medical Council.

Charlotte Leslie: No; she is a member of the medical profession.

> ***Niall Dickson***: She is a registrant like everybody else. She was treated like anyone else who has had a complaint made against them, except that we got senior counsel to oversee the decision, check through the investigation and give us advice on what was the right way forward. The advice we got was that the evidence we had managed to gather was not sufficient to get to a point where we would be able to find Dr Hakin's fitness to practise impaired. I know that is a very clinical-style answer, but we did a thorough investigation. It would be inappropriate—and I do not have the evidence here—to exchange what A and B said and all the rest of it. All I can say is that we approach this in good faith. We certainly do not have a bias towards somebody who has a particular job in the Department of Health or anything else. Our job was to assess this.
>
> These are difficult issues when you are dealing with management and policy decisions that are quite a long way from clinical practice; they are complex. We had to judge whether her behaviour amounted to a level of bullying, for example, that would justify our taking action on her registration. The external advice that we got on the basis of that investigation was that we did not reach that threshold.

Q52 Charlotte Leslie: Earlier,, you said that if there was conflicting evidence it would be shared, but the GMC did not share the counter-evidence that Barbara Hakin presented to the initial complainant, so the complainant was not given the opportunity to say, "No, that's incorrect because…" Earlier you assured me that that always happened, but it did not happen in this case. You say you did not have the evidence, but it does not seem that the GMC fulfilled its duty in demanding the evidence that it should have done.

Niall Dickson: Again, it is slightly difficult to go into the detail of this.

Chair: I would like to suggest that you think about what has been said, which clearly might be seen as controversial, and write to the Chair of the Committee about these remarks when you have had a chance to consider your opinion.

Charlotte Leslie: I do not want to bore the Committee now, but may I write to the GMC, and perhaps you would be able to answer me in a letter?

Chair: I think that is fair, but we have had a fair run at this. This is clearly controversial territory. If I were in your position, Sir Peter, it is not something I would want to answer on the hoof. I think it is reasonable to suggest to you, having heard what has been said—and you can read the transcript—that you can write to the Chair in reasonable time.

Q53 Dr Wollaston: Coming to the pilot programme whereby doctors can avoid a hearing if they accept a sanction in a clear-cut case, it was quite a controversial area because many members of the public expect to hear a doctor coming to give evidence in public. Can you explain to the Committee the outcome of your pilot?

Niall Dickson: We are only part-way through the pilot. The early results are positive in the cases we have done so far. We are able to operate this at the moment only with lesser sanctions. We are not able to deal with it, as we would eventually like to do if we get legislative power, by way of suspension or erasure. Those cases currently still go to the panel. We are trying out a process.

When we get to the point I described earlier with the two decision makers, the doctor and the lay, instead of them simply deciding on the basis of the written evidence, including exchanging evidence and challenging those who have produced it, we have a meeting with the doctor at that point where we say, "This is the evidence we have accumulated as a result of our investigation." The doctor may have additional things to say. With things going backwards and forwards, there can always be additional things they want to say at that point. At that time we would say, "We think this is the appropriate sanction that needs to be taken in order to protect the public." The doctor then has a choice. They can say they accept the sanction—as in somebody pleading guilty in a court, all of that would be in the public domain, so nothing is being hidden away. If they do not accept that and think the sanction we are proposing is not appropriate, or they dispute the facts, the matter would continue to go to a hearing.

The results so far are very positive. We will have to publish the results of the pilot and so on, but at the moment we believe it will mean that we can take appropriate action against doctors where we think the public is at risk, and we will shorten the process and avoid some hearings that would otherwise have taken place but produced the same end result in terms of protecting the public.

Q54 Dr Wollaston: When you say they are successful, are you judging that in terms of shortening the procedure, or are you gauging how the complainant feels about it? How are you measuring it when you say it is successful?

Niall Dickson: We will have to look at all those things, and we are running a separate pilot, as you know, with complainants whereby we are having meetings with them. As far as the meetings with doctors are concerned, the measure of success would be where doctors accepted our sanction. We are proposing that the Professional Standards Authority is able to audit all our decisions in this area so it is able to see and judge whether we are making the appropriate sanction based on the evidence. It is important that there is external scrutiny of that process. It is a combination of things. If doctors accept the sanctions, we are shortening the process and they are feeling better about the process as a result, and if witnesses are not put through the trauma of having to appear in front of a hearing and we are succeeding in protecting the public, those are certainly the aims we would hope for as a result of the pilot.

Q55 Dr Wollaston: But you will be carrying out a study with complainants to see how satisfied they are with this alternative procedure.

Niall Dickson: Yes. The GMC is the body taking these cases through, not the complainant. In the past, we used to have a system where complainants were parties to it, but it is the GMC taking it forward. But, absolutely, at the same time we are having meetings with complainants and monitoring that process as well. We are having two meetings with them, one at the start of the process and one at the end, and hearing what they think about the process.

Q56 Dr Wollaston: What criteria are you using to establish that a doctor has developed better insight into the failings that led to the complaint in the first place and, critically, has changed their performance? Do you follow up the result of it?

Niall Dickson: This is something we need to look at some more, to be frank with you. The general approach in the past has been that the doctor shows insight and says, "Yes, I admit I did it and I have done a course and started to mend my ways" and so forth. We certainly want to explore whether doctors might make an apology to the complainant, which is not part of either the panel's process or our process. It is an area we will be looking at.

Currently, we are also having discussion with the Department of Health in the run-up to the Bill about whether insight itself is enough in our being able to reach the right sanction. In other words, under the case law as it has developed, where a doctor shows insight and says, "I'm all better now; everything is sorted" and so on, there is a tendency for the system to say, "The doctor has shown insight, contrition and so forth, and therefore they are not a future risk to patients and there should not be any action or lesser action should be taken against them."

The discussion we are having with the Department of Health is about whether there are circumstances where a doctor has been reckless—that is to say has caused harm to patients or put them at risk, and they should have known that—but there is an accountability line that should be applied. In other words, we should be concerned about the reputation of the profession as well as the safety of patients, and we have to get that balance right. Parliament will have an opportunity to debate—I know it sounds quite a technical issue, but it is a very important one—how we get the right balance between not trying to punish doctors

but, on the other hand, holding them to account where the public would expect them to be held to account.

Q57 Dr Wollaston: I guess what I meant was how far you go in following up whether the sanctions have been complied with. Does it get flagged up in their appraisal and fed back to you that their behaviour has changed?

Niall Dickson: If we put in place conditions or undertakings, which are voluntary conditions, on a doctor's practice, we absolutely follow that up, and we have a whole team of people who spend their whole time finding out and checking that the doctor is doing the things that either the panel has ordered or we have required of them.

Q58 Andrew George: In cases where a fitness to practise hearing is not proceeded with, how does the GMC ensure that that is appropriately communicated to both the complainant and the doctor subject to the complaint?

Niall Dickson: The law has not changed at the moment, and we are in the same boat. We still have to discuss exactly how we will do this, but, in principle, we are hoping to make it as transparent as possible. Obviously, anything that is done to a doctor's registration appears on our register, because there is anxiety that somehow this is all behind closed doors. I use the analogy again of a criminal case. Where somebody appears and pleads guilty, you do not go through all the evidence in court in that instance. In this instance we would make absolutely sure that it was known to the complainant. We would contact them and make sure they were informed of the action that had been taken. As we work through the meetings process, we would probably have a meeting with the complainant and discuss with them what had been found and said.

We have to work out what we would put on the register. The decisions would absolutely be on there, so it is not a question of covering up any of that. If there were public interest in it, we would issue a press statement and so forth. We have to work out the granular detail of this. At the moment, we are dealing with much lesser things because that is all the law allows us to do, but, if we get legal change, we will certainly be absolutely clear that these are made public.

Q59 Andrew George: I have given you advance notice of a specific case. I am not gong to refer to it or ask you to comment on it, but matters of principle arise as a result of this. I have had quite extensive correspondence with the GMC in relation to this particular case. If I simply give the principles, this relates to a hospital death in April 2006. In 2008, the Healthcare Commission issued a report highly critical of the doctor responsible for this particular patient, and the GMC decided not to proceed with a fitness to practise hearing in 2009.

A coroner's inquest in 2011, nearly five years after the death, identified that this was an avoidable death caused by failure of basic standards of treatment by the doctor concerned. It ordered the issuing of a fresh death certificate referring to the inappropriate use of "do not resuscitate" orders and effectively demonstrated that the GMC's decision not to proceed with a hearing was flawed. The GMC then decided not to reopen the hearing, or not to institute a fresh hearing, in the light of that evidence.

My constituents who have raised this case with me feel deeply frustrated. I guess it is a common pattern, whether they are dealing with ombudsmen services or others. They feel they are engaged in a complaint management system rather than a genuine investigation, which is sapping their energy and attempting to bamboozle them with the sophistry and artifice that is sometimes deployed to push such complainants away.

The point that arises is that, where another statutory body—in this case the coroner—comes to a significantly different conclusion from the one the GMC has already come to in deciding not to proceed with a fitness to practise hearing, it seems to me from this particular case that the GMC automatically becomes very defensive and defends its original decision. My question is, on how many occasions has this happened? How can you reassure me that the GMC takes this on the chin, as it were, and does not automatically go into defensive mode?

Niall Dickson: First, I am sure that organisations do go into defensive mode. I certainly hope that the staff who are dealing with this, who quite likely were not around in 2006, are not going to be very defensive. There are certain things that we are bound by under statute. One of them is the five-year rule, which says you may not open up cases after five years unless these things are met, and it is a very high bar.

Andrew George: Is that five years from the death or the decision of the GMC not to proceed?

Niall Dickson: I would have to check, but I think it is five years from the incident itself.

Andrew George: That is important, because it is quite a long time delay.

Niall Dickson: Indeed it is. There are circumstances in which you can override the five-year rule, but it is a very high legal bar. That is the first point. I am very glad that you did not ask about the details of the case, because I am sure we could get into all the different circumstances.

I do not think my staff are very defensive about this kind of thing. The reality is that we open up cases where we have made mistakes on a fairly regular basis. There is a thing called rule 12, which is a process we go through to look at decisions we have made. We regularly order reviews and then open up cases where we have made mistakes in the past. I hope that, in principle, we are not defensive. Clearly, we do not get decisions right every time; we do make mistakes, but I hope that in the kind of case you have described we would look at it very closely. We would be concerned about both the medical advice and legal advice we got at that time and about what we were able to do at the point you were raising this.

Professor Sir Peter Rubin: To make a very general comment, I am aware of a number of cases where Niall as registrar has reopened a case, only to have to close it again under legal challenge. The five-year rule is enshrined in law. There will be many times when we will share your frustration.

Q60 Chair: How many cases are we talking about that you have reopened? What is the critical mass of reopened cases?

Niall Dickson: I will send you a note on the number of rule 12 cases. The rule 12 group meets regularly, so the decision to reopen is fairly regular.

Q61 Chair: We have just changed the law on double jeopardy. Do you think you now need to address that issue when it comes to doctors? Do you think we should do that? I do not know whether that is something Andrew was going to move to.

Niall Dickson: I might defer to David on this. This also concerns human rights law.

Chair: His Honour has been sitting quietly for a long time. Perhaps, Judge, you would like to contribute.

His Honour David Pearl: I am very happy to sit quietly if you wish. Obviously, I am concerned with cases only once they have been referred by the GMC to the MPTS, and this separation is a very important one. If I were to answer only on the basis of a decision taken by an MPTS panel, that is all I can say. I cannot answer for the rule 12 issues where a decision has been taken not to proceed.

There are two points to make. First, the panel is not out to punish. We are not a criminal court; we are not punishing doctors, if we have made a decision against the doctor. As we have all said, it is a question of the protection of the public and patient, and that includes the reputation of the profession. If a panel has made a decision in favour of the doctor and the GMC does not like it, the GMC has no right of appeal. This Committee has said on at least two occasions now that it would favour giving the GMC a statutory right of appeal. I certainly would be very much in favour of that. The GMC is in favour of it, and we would hope that legislation would allow an appeal to be taken by the GMC if a panel has made a decision that, frankly, cannot be supported on the facts of the case. At the moment the doctor can appeal but the GMC cannot. I would hope that that would deal with the sort of issue that arises when a decision is taken that cannot be justified.

Niall Dickson: There will be an opportunity for Parliament, if this Bill comes before it, to look at the five-year rule. I absolutely understand the human rights argument that somebody should not be sitting there with a complaint for years and years and suddenly produce it when the evidence tends to be very stale, it is very difficult to prove anyway and all that kind of stuff. There are circumstances where, clearly, we would like to be able to pursue this. This is a real public policy issue that people have to discuss. There are two balanced rights to be considered, and it is absolutely appropriate that Parliament discusses that when the Bill goes through.

Q62 Andrew George: Can I come back to your defence, or explanation, rather, in relation to rule 12 and relate that also to rule 28? Obviously, you know what all these 28 rules say—or presumably more than 28 rules. For example, in this particular case the GMC's head of investigations wrote to my constituent with counsel's advice. It said that that advice agreed with the stance previously explained regarding the application of rule 12 to cases cancelled under rule 28, specifically that the GMC had no implied or inherent power to review a decision to cancel a hearing under rule 28. It is only the High Court that has the power to quash such a decision.

In this particular case—I guess it is not alone—following, for example, the coroner's inquiry, we are looking at fresh evidence. It is the same person and event, but it is a new hearing in the light of a whole set of new evidence that has come to light which the GMC completely

missed on the previous occasion. The question really is, first, is rule 12 being applied appropriately? Secondly, you talk about the opportunity for Parliament to review decisions in relation to the five-year rule. Will there be, or indeed are there, opportunities for the GMC to make recommendations to itself to change its own rules if they are constraining it from pursuing logically, on the basis of basic justice, cases that clearly need to be not so much reopened as restarted?

Niall Dickson: My understanding is that this is stuff in statute, so, no, we cannot change the rules ourselves.

Andrew George: No, you can't change the rules.

Niall Dickson: You can change the rules; you can do that. I do not think we should get into the minutiae of this. I am really happy to answer any questions around this case, how we applied the law and who we went to in order to get advice on it.

On the principle, I think it is legitimate for Parliament to have consideration of the five-year issue and weigh up the balance. That will apply not just to the General Medical Council but presumably to all the professional health regulators. If you are asking whether we applied the rules correctly in this case, I believe we did, but I will need to go into the details in respect of that.

Q63 Andrew George: One of the themes that arose in this particular case and, I understand, arises in a large number of others is the application of "do not resuscitate" orders in relation to patients. On this occasion the finding, certainly in the narrative conclusions in the coroner's report, suggests it was inappropriately applied to a patient whose death was avoidable. Is there a pattern in the medical profession where, increasingly, there are cases of an alleged inappropriate application of "do not resuscitate" orders, in which we should consider the extent to which the proper procedure is gone through—discussing it with the patient and/or their family and seeking the opinion of other colleagues before such decisions are taken—so that the consequences are fully explained to those who are going to be affected?

Professor Sir Peter Rubin: Rather than give the Committee an off-the-cuff answer, I think it would be far better if we could take that one back, ask about it within the organisation and get back to you with information. We could not give you an assured answer on that one.

Q64 Chair: I want to move on to issues to do with ethnicity. What work have you undertaken to understand why a disproportionate number of black and ethnic minority registrants are subject to fitness to practise proceedings?

Professor Sir Peter Rubin: This has been a subject of interest to the GMC for a very long time. We have commissioned a great deal of research in this area, all of which we have put in the public domain. If a doctor has qualified outside the UK, irrespective of their ethnic background, they are more likely to be referred in to our procedures than if they have qualified within the UK. This has been a well-established fact. It has also been established by a number of inquiries and research projects that our procedures are absolutely fair and robust, and once a doctor is referred to us our processes are robust and not discriminatory. But this factor is about non-UK graduation rather than ethnicity. That is the factor.

Chair: I understand; fair enough.

Q65 Mr Sharma: Does that apply to EEA doctors?

Professor Sir Peter Rubin: Oh yes, I am including EEA in that, absolutely. If you graduated elsewhere in the European Economic Area, you are more likely to be referred in to our procedures than if you are a UK graduate.

Niall Dickson: In addition to what we have just said, we are doing more research into this with King's College, I think, but I will check. We are doing more academic research to try to look at our procedures again. Some of this is quite complex—to understand the nature of the concerns presented to us and then the outcome at the end, and obviously the two things have to match up. We continue to look at this area to make absolutely sure that we are treating people fairly. As Peter says, there is a significant issue around doctors who come with overseas qualifications. We are taking steps—not least, we are piloting an induction programme for those doctors, because they themselves have said in studies and so on that they feel isolated and want additional support. We also hope that good RO arrangements will again also help. Practising medicine is a set of skills and competencies, but it is also culturally specific. Therefore, it can be difficult for people who are coming from other cultures.

Q66 Chair: I understand exactly what you are saying, but have you looked at the English language issue—whether doctors can speak the language?

Niall Dickson: Yes; there is the change in legislation that we have proposed.

Chair: We will leave that, because we are coming to that further on.

Q67 Grahame M. Morris: I do not know whether I should address this to David Pearl. I am not sure how I should address you. Is it "Your Honour"? I am not sure; it sounds very deferential.

His Honour David Pearl: I am very happy to be called David.

Grahame M. Morris: I want to ask some specific questions related to doctors who have criminal convictions, about which there has been a bit of publicity. It is reported that over 700 doctors have criminal convictions and yet they are still on the register as being fit to practise. It says in the evidence that there are exceptional circumstances where a doctor would not be struck off. Could you elaborate on what they would be?

His Honour David Pearl: Can I give you some figures? I did look into this. These are the figures from June 2012 to December 2013. The MPTS has been in existence for that period of time, so these are MPTS decisions. I am not talking about any decisions prior to that. In that period of time we had 61 fitness to practise cases dealing with doctors with a criminal conviction. Of those 61 cases, erasure plus immediate suspension was made in 27 cases, which is 44.3%. There was suspension in 26 of them, which is 42%. Of the 61, you have a large number of those cases resulting in either erasure or suspension.

At the other end of the scale, there were just four cases out of 61—I will mention those in a moment—where there was either no impairment with a warning, no impairment at all, or impairment and no action. I have looked into those cases, and they were all relatively minor

matters. I say "minor", but they were matters in relation to which perhaps the public—the community out there—would not be surprised to find the doctor was still in practice. There was a conviction but it was for a minor driving offence.

Q68 Grahame M. Morris: I understand. Under what "exceptional circumstance" is it possible that a doctor with a criminal conviction for possession of child pornography, for example, is allowed to continue in practice?

His Honour David Pearl: I would hope not. If that sort of result was produced by a panel, I for one as chair would be most concerned.

Niall Dickson: The figures that were given are old, in the sense that they are a snapshot of the register at one time, but the answer is that there are three doctors currently on the register who have had convictions in that area. Two date from 2004 and one from 2006. I believe, though I am not sure in every case because it is quite a long time ago, that the GMC called for their erasure at that time. To be absolutely clear, the leadership of the General Medical Council and all its bits would absolutely, every time, in the instances you are referring to, want to see the doctor erased. If you give us the right of appeal and the panel does not, we will do it. This is not a debatable issue. Looking back and seeing things in the past, they are still there; we have to manage that process, but we are absolutely clear about the stance we would take on these matters.

Q69 Grahame M. Morris: On offences of a sexual nature, in particular anything involving violence, the GMC and Medical Practitioners Tribunal Service would take a dim view in terms of fitness to practise—and being in possession of images of children, child pornography, again would come into that category.

Niall Dickson: We have said publicly that we think those things are incompatible with being a doctor. If you can give us the legislation, that would be very helpful. We would automatically strike off those doctors. Obviously, every case would have to be looked at, but the presumption would be that they would be removed without going to a hearing. They would still have an appeal to the High Court if they thought the registrar's decision was inappropriate, but the signal is absolutely clear. We simply should not tolerate that.

Grahame M. Morris: It is useful to have that on the record.

Q70 Mr Sharma: In the Committee's report last year emphasis was placed by the Chair on "consistency in decision making, the effective management of its cases and the dissemination of best practice." What steps have you taken in the last 12 months to improve the consistency of decision making in the Medical Practitioners Tribunal Service?

His Honour David Pearl: We have taken a number of measures. The first is that we have a quality assurance group, which I chair. That group looks at almost all the decisions taken by fitness to practise and interim order panels. We meet regularly every four weeks and look at all of those cases. If there are learning issues or concerns, I take it upon myself to write to all three members of the panel and the legal assessor about those issues to ask them to reflect, because it is part of the training.

As to the second development, we have instituted a training programme for all of our panel members, both the long-standing ones and the new ones. We have a lot of new panel

members. That is a very regular training programme of a residential kind, five days a year for new members and regular annual training for existing panel members, where we look at all of the trends in case law and the procedures to ensure we have consistency.

The third very important introduction is a system of mentoring for newly appointed members and appraisal, especially for our chairs. I and some of my colleagues sit in on and observe many of the hearings, including the "in camera" discussions that take place, to ensure that there is consistency in the way in which the panels are discussing cases. We emphasise reasons. It is very important that when the panel reaches a decision it gives very clear reasons, obviously for the doctor but also for the profession at large, the complainant and indeed the GMC, because that is the body bringing the case. We publish those decisions. Everybody has a way of seeing exactly the way in which the panel has reached its decision.

Measurement is always rather difficult in this particular area. No two cases are exactly alike, but it is at least reassuring to know that, when doctors have taken cases to the High Court on appeal under section 40 of the Medical Act, certainly in the last six months or so, the decisions of the panel on the findings of fact, impairment and any sanction they have imposed have by and large been upheld. The most recent cases have upheld the decisions of the panel, so there is an external review of what is going on.

Q71 Mr Sharma: I was going to ask whether it was internal or external. You have already made that clear. Do you still expect that by the middle of 2014 the Government will introduce legislation to allow you to appeal decisions taken by the Medical Practitioners Tribunal Service?

His Honour David Pearl: I cannot give an exact date. All I can say in relation to your question, and indeed any other changes—and we would very much like to see a number of changes in the legislation—is that I hope that that would be in place before the next general election at least.

The changes we would like to see are, first, the right of appeal in the GMC, which we have already talked about, and, secondly, a costs regime. We are introducing case management in a very detailed way. Case management is really the key to having effective hearings where all of the issues of procedure and, if you like, legal applications are dealt with before the hearing starts, so that time is not wasted in legal argument on the first day of the hearing. The only way in which we can get the parties—the GMC as well as the doctor's representatives—to comply with directions is to say to them, "If you behave unreasonably in the conduct of the proceedings, there is a cost implication." We would very rarely use that, but at least it would concentrate the minds to ensure that case management was complied with. But again, that would require a change in the legislation.

As to the third area that we would like to see in the form of legislation, at the moment the Medical Act states that the appointment of a legal assessor is mandatory. Legal assessors play a very important role in many of our hearings, but there are other hearings where, quite frankly, there is no law involved. In particular, in review cases and many of our interim order panel hearings, there is really no law; it is an assessment of risk. With a robust chair and well trained panel, it is not necessary to have a legal assessor appointed to be in place, at some cost to the profession. We would like to see the mandatory requirement replaced with a discretionary one.

Finally, we would also like to see a change in legislation to put the MPTS on a statutory footing—at the moment we do not have a statutory base—so that we would be accountable as the MPTS to Parliament, perhaps with an annual report to this Committee from them.

Professor Sir Peter Rubin: In answer to your question, perhaps I may say something so that it is written into the record. As we were leaving the office today, I received a letter from the Parliamentary Under-Secretary of State for Health indicating that the section 60 order, to which David referred, will not progress in 2014 but will be incorporated within the Bill as a result of the Law Commission inquiry. In the same letter, I was assured that the English language testing amendment will progress in April 2014, so it is a mixture of goods news and not so good news. The changes to which David refers are very important, but the view is that they affect more than one regulator and, therefore, there is logic in incorporating them in a single Bill.

Q72 Mr Sharma: My apologies. I should have been very clear when I put the last question to you that, in 2012, the GMC was expecting that to be introduced in 2014. That was the question.

Professor Sir Peter Rubin: We were indeed.

Q73 Chair: Sir Peter, was that why you were shaking your head vigorously during the question before that?

Professor Sir Peter Rubin: Because I knew that the answer to the question was no, but the letter, quite honestly, was received by e-mail literally as we were walking out of the door to come here, so it is very much hot off the press.

Chair: I thought you were in conflict with Judge Pearl's opinion.

Professor Sir Peter Rubin: No, never.

Chair: I was really getting quite excited about that controversial stuff.

Dr Wollaston: Will you be writing to ask if Dr Poulter will send us a copy of that for our inquiry, as well?

Chair: I see no reason why not.

Q74 Charlotte Leslie: I was going to ask when you expected the amendment relating to language testing to take place, but you have anticipated me. It has been frustrating for all of us that we are dependent on Europe on language testing regulation. Is there more that the GMC can do, or could have done—other European countries deal with this differently—to separate the registration process from the recognition of qualifications without the need for legislation change?

Professor Sir Peter Rubin: We could not have done it without domestic legislation change. We have been very much in the lead on this one. We have pushed for this change for most of the time that Niall and I have been in our current roles. It has taken longer than we ever imagined it would, but we will be getting there, and the letter which we received today has assured us that it will happen in April 2014.

Q75 Charlotte Leslie: That is very welcome news. In the consultation on amending the Medical Act, in 2011 I think 66 cases were identified where responsible officers had dealt with linguistic concerns about a doctor. Do you have any updated statistics? Has that number risen?

Professor Sir Peter Rubin: I do not know the answer to that.

Una Lane: As far as what responsible officers might do locally is concerned, we would not be personally aware of whether there were issues that they felt they needed to address in relation to individual doctors. We know of concerns raised at GMC level. I think there have been 12 cases in the last 12 to 18 months—we need to check this—in which an individual doctor's ability to speak English was certainly a significant element of the concerns raised with us. We can double-check the figure for you and write to confirm that, but it was in and around that number.

Q76 Charlotte Leslie: With the explicit duty in legislation on responsible officers to ensure English language competence as part of the recruitment process, does that mean that the responsibility for language testing will rest with the employers?

Niall Dickson: There are two steps here. First, the Medical Act, as we have long argued, prevents us from doing anything in relation to the testing of language. The change that will go through now will expose us to European law in that sense, so we are hoping to set up something that is compliant with current European law to give us the ability, if we have a doubt about a doctor's language abilities, to do something about it, and there are some other provisions as well.

The second defence is that we now have responsible officers with a very specific duty when they take people on to make sure the individual is language-competent. European law is also going to change. We have done a lot of work in trying to persuade other countries to go along with this. Other countries have similar concerns about doctors crossing borders and not having this ability, so European law is going to change to allow all competent authorities covering all health professions to test on a more routine basis to check that individuals have language competence. That is the next step, as it were, but we are going through the first step of unlocking the UK legislation and constructing something with the responsible officers, which, combined, is not perfect but much better than we had.

Q77 Dr Wollaston: Can I come to the issue of transparency and conflicts of financial interest? Is it time for the GMC to set up a register whereby it is easy for the public to check whether a doctor has a conflict of interest? It might be a journalist, for example, writing articles that have been influenced by payments by a drug company, or consultants speaking at very lavish conferences. There are many examples of where people have concerns. The procedure we now have for MPs is very straightforward. Is it time to have the same for doctors?

Niall Dickson: I think we are on the verge of a revolution in information and what will be available. We guard what is on the register quite carefully, so everything currently on the register is a fact; it is not a matter of debate or discussion. However, we have said that we will look at the register and accessibility to it. Additional information will almost inevitably come out as a result of the revalidation process, but we are also going to look at

how useful the register is. As part of that, we will look at conflicts of interest, the practicality of it and whether we will be able to do it. I am not giving any guarantees, but it is part of our wider look at how we can make the register as useful as possible. Doctors absolutely have an obligation under our guidance to record and make clear any conflicts of interest they have, and we have reinforced that guidance in recent times.

Q78 Dr Wollaston: Where can the public access that information? It might be difficult for a member of the public to see that in a consistent fashion. Where are you advising doctors to record that?

Niall Dickson: The normal circumstances where a doctor would have a conflict of interest would be, I guess, in their individual practice; it would be at the surgery—if they had, for example, ownership of a care home locally and they were part of that, or if they were members of a clinical commissioning group. Clinical commissioning groups should be publishing the conflicts of interests of all their members.

Q79 Dr Wollaston: What about a consultant who is accepting quite lavish hospitality and payments to speak at conferences from a drug company? How would a member of the public know whether there was a financial conflict of interest in their practice?

Professor Sir Peter Rubin: The simple answer is that they would not. We recognise the importance of this area, Sarah. As you may recall, I wrote to every doctor ahead of the NHS changes in England to remind them about their responsibilities here. At the moment we are dependent on local custom and practice and local organisations declaring this stuff. We can see the merit of the argument. The devil would be in the detail—about how current it is and all that stuff—but we are committed to the register being a good deal more useful than it is now, while retaining its accuracy.

Q80 Dr Wollaston: The way the register works in Parliament is that it is an individual parliamentarian's responsibility to keep that up to date. Therefore, it is not about saying that the Commons registrar takes responsibility for it; the individual Member has to take responsibility for any omissions, and it is there on the public record if they have not complied with that.

Professor Sir Peter Rubin: Absolutely; indeed. Of course, the electronic register would open itself to the possibility of that happening in a fairly straightforward way. We were looking at the usefulness of the register anyway, and this is a very timely moment to look at this very important aspect.

Dr Wollaston: So you will be considering that in the future.

Professor Sir Peter Rubin: We absolutely will.

Q81 Dr Wollaston: The other area I want to touch on is the issue of drug trial transparency. Are you prepared to alter your guidance so that doctors are able to participate in a clinical trial only if it is registered and the methods and results are made publicly available?

Professor Sir Peter Rubin: Niall has been having discussions with the research community on this. The issue here is that we recently changed our "Good Medical Practice" guide, which is our headline guidance, in the light of an extensive consultation that wanted it to be shorter. When something is shorter, you take things out. We have

supplementary guidance, which includes research, and the point you make is implicit but not explicit in that guidance. We are having discussions with the research community about tweaking the wording. It is more likely to be tweaked in our research guidance and brought back into "Good Medical Practice". Nevertheless, those discussions are under way.

Q82 Dr Wollaston: There is one specific area about an omission in making it shorter. The GMC has removed the guidance that doctors, as it says here, "must work with colleagues and partners to help resolve uncertainties about the effects of treatments." There is great concern among many organisations that that is downgrading the importance of transparency of drug trials.

Professor Sir Peter Rubin: Negative trials and things. We accept that.

Niall Dickson: There are two issues. One is how we are transmitting to doctors the importance of research. Because that was squeezed out of "Good Medical Practice", we have said we will put it into the supplementary guidance. We are adding into the supplementary guidance that which was in the shortened version of the GMP. We have also given an undertaking to write through our e-mail process to every doctor in the country highlighting the fact that we have done this.

On publication, to build on what Sir Peter said, we have asked the Health Research Authority whether there is wording that it thinks might go into our guidance to reflect the point about publication. We are in the middle of ongoing discussions about this. There was a view in the GMC in the past that, once we put guidance out, it was in stone. Because we have been through a very tortuous process of consultation and so forth, we have a slightly more flexible approach now. In the past you would have to reprint the whole thing and all the rest of it. We can make tweaks to guidance where we are absolutely clear that that is a right and appropriate thing to do. In this instance we have agreed to add to the supplementary guidance, and we are having discussions with the research community on the issue of publication. Our view, incidentally, is that it is absolutely clear that doctors cannot do research and then decide the results are not to their liking and not publish them, but if there is clearer wording that we can put in, we will do it.

Q83 Dr Wollaston: Can you say how many times a fitness to practise hearing has taken place as a result of doctors not publishing inconvenient results?

Niall Dickson: I would have to come back to you on that. There are cases involving various aspects of research which do come through the fitness to practise process, so I can come back to you on the figures on that.

Q84 Dr Wollaston: But do you feel it would be appropriate to refer a doctor to a fitness to practise hearing if it came to your attention that they had knowingly failed to publish inconvenient data?

Niall Dickson: I would absolutely have thought that any doctor who was suppressing research information would be the subject of an investigation.

Professor Sir Peter Rubin: The landscape has changed recently. There was a time when it was very difficult to get negative studies published in peer review journals, so a doctor, try

as he might, just could not get it published. Now, with open access, you can put your results online and they are there without peer review. The landscape has changed, and there is now no justification for negative, seemingly boring, results to be withheld; they can be put into the public domain.

Q85 Dr Wollaston: In the past, one of the problems was that doctors might have felt pressured by drug companies not to have this on the face of their contract. Do you think there is a role for the GMC in making it clear that no doctor can accept—

Professor Sir Peter Rubin: It is incompatible with our guidance, is it not?

Dr Wollaston: In other words, you would say that no doctor should accept a contract which did not have written into it a duty of transparency.

Professor Sir Peter Rubin: That is already incompatible with our guidance. However, our guidance is wide-ranging, and sometimes it is helpful to bring it all together in one place. Niall is having discussions about what wording would be appropriate.

Dr Wollaston: So it is ongoing, and we can ask you about this again next year.

Professor Sir Peter Rubin: It is ongoing.

Q86 Chair: Before we finish, I would like to ask you two further questions. To go back to personal choice, under the Medical Act 1983, which provides your governance, you are required to foster good medical practice and promote high standards of medical education and training. I suggest that, with health and wellbeing boards and personal budgets, you now need to look at a wider range of medical services that are out there.

If we go to the long-term care inquiry that we are in the process of holding, the evidence given by Professor Lewith, professor of health research at Southampton university, was that each year 15% of the population look at CAM—complementary and alternative medicine—and sometimes up to 90% for chronic and long-term conditions. He also told us, "We know with cancer that people who use complementary medicine on their cancer journey, which is between 20% and 40% of people with cancer, get a huge amount of ability to self-care and a lot of positive survivorship skills from using complementary medicine, not as a cure but as a long-term survivorship process."

Sir Peter, going back to your earlier remarks, when you basically agreed with what I was saying, could you expand on that and tell us how you see the paradigm developing, given the new circumstances?

Professor Sir Peter Rubin: In our education guidance we require that undergraduate medical students are taught about alternative medicine and complementary therapy because, as you say, it is the real world; people are using alternative medicines extensively.

Q87 Chair: My colleague was telling me that Bristol medical school is now teaching complementary and alternative medicine.

Professor Sir Peter Rubin: Yes, and that is probably the result of our guidance which introduced this for the first time when we last published it two or three years ago. We are

very keen that the world as it is should be reflected in our guidance. Long gone are the days when a doctor would be very dismissive of alternative approaches to treatment. Whether they are alternative therapy of the sort you are describing, chiropractors or whatever, if it works and it is safe, fine.

Q88 Chair: My last question relates to a current issue, which is the regulation of herbal medicine. Your sixth strategic aim is "to help shape the local, UK, European and international regulatory environment through effective engagement with decision makers, other regulators and key interest groups." I have been asked to serve on the herbals working group by the Minister, Dan Poulter. I am going to be the vice-chair of that group under Professor David Walker, the new deputy chief medical officer. We will be taking submissions about how we get herbal medicine to interface with European legislation, which is a requirement, and this will be done over the next year.

Given what I have just read out to you about your strategic aims, do you have a view on whether there should be statutory regulation or voluntary self-regulation in this case? If you have not formed a view, would you please form one in line with that requirement? There are those lobbying very strongly for statutory regulation and some who say it could be dealt with by voluntary regulation, so it will go either to the Professional Standards Authority—I do not expect it will come your way—or to another organisation that could possibly do it. Given that this is part of your strategic aim, would you write to the Chair of this Committee and express a view, which I can then take to the herbals working party, which will start work in January?

Professor Sir Peter Rubin: We will undertake to do that.

Chair: You will write to the Health Committee.

Professor Sir Peter Rubin: Yes, we will.

Chair: Una and gentlemen, thank you very much for a very long and worthwhile session. You have made a great contribution this afternoon, and I thank you on behalf of the whole Committee.