



Health Committee

Oral evidence: 2015 accountability hearing with the General Medical Council, HC 846

Tuesday 6 January 2015

Ordered by the House of Commons to be published on 6 January 2015.

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Members present: Dr Sarah Wollaston (Chair), Andrew George, Barbara Keeley, Charlotte Leslie
Grahame M. Morris, Andrew Percy, Mr Virendra Sharma, David Tredinnick, Valerie Vaz

Questions 1-109

Witnesses: **Professor Terence Stephenson**, Chair, General Medical Council, **Niall Dickson**, Chief Executive and Registrar, General Medical Council, **Dr Judith Hulf CBE**, Senior Medical Adviser and Responsible Officer, General Medical Council, and **His Honour David Pearl**, Chair of the Medical Practitioners Tribunal Service, gave evidence.

Q1 Chair: Good afternoon and happy new year. Welcome to the Health Select Committee hearing on the General Medical Council. For the benefit of those following this, could you introduce yourselves, starting with Dr Hulf?

Dr Hulf: I am Judith Hulf. I am the responsible officer and senior medical adviser to the GMC.

Niall Dickson: I am Niall Dickson. I am the chief executive and registrar.

Professor Stephenson: I am Terence Stephenson. I am a practising doctor and chair of the GMC. This is my second working day as chair of the GMC.

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

Q2 Chair: Thank you. Welcome, Professor Stephenson, to your new role. Perhaps you could open this hearing by setting out your priorities for your term in office.

Professor Stephenson: Thank you. I will keep it very brief. I plan to summarise it under the four roles that the GMC has: responsibility for all the education and training of doctors in the United Kingdom; maintaining the register that tells the public who can practise as a doctor; upholding professional standards; and—what we are probably best known for—the fitness to practise area, when people do not maintain their standards. Under each of those

four headings, I would like to say something about an achievement from the past year and an ambition for the next year.

Under education and training, the “Shape of Training” report, chaired by Professor David Greenaway, was published in late 2013. After something of a hiatus in 2014, we have been trying to lend our shoulder to move that forward. We think that would commend itself to you. One of the things I think you were interested in is the idea of doctors being generalists, and Shape of Training is something we may talk more about, which would lend itself to pursuing that. At the moment, it is with Ministers of the four Departments of health; civil servants have made recommendations, and we look forward to hearing the outcome. In 2015 a big piece of work for us will be that the GMC council has agreed, at least in principle, to look at the concept of a national licensing exam, something in which I think this Committee has been interested in the past. That will be something we will be taking forward.

Second is revalidation and registration; 75,000 doctors have now been revalidated and I am one of them. I have been revalidated: I have walked the walk and I have been revalidated until March 2018. My personal perception of it was that it was not overly bureaucratic. I know from talking to my colleagues that it has made people take appraisal and feedback from colleagues and patients a lot more seriously. It is a very important step forward for this country, showing the public that doctors like myself, who last took a professional exam in 1986, are fit to practise. In terms of looking forward, we agree with you that the medical register is not that different from when first conceived—in 1858, or something. We think it could be of more value to the public; it could contain more information and be more useful.

On professional standards, in 2014, following the Francis inquiry on Mid Staffs, the GMC, with the Nursing and Midwifery Council, launched a joint consultation on a professional duty of candour as distinct from an organisational duty of candour. The responses to that are coming in and we will be reviewing them early in the new year. We are also rolling out in 2015 a very successful “Welcome to the UK” programme. We remain a health service and country very dependent on other nations for our medical work force. That being the case, it behoves us to provide them with a proper induction into the UK national health service. That has been a very successful programme and we will be rolling it out in 2015.

Finally, under fitness to practise, a year ago you made a request of us that at least 90% of inquiries were dealt with within 12 months. I am pleased to say that over the last year it is 91%, so we have met that target.

Going forward, we hope in 2015 that this House will pass the section 60 amendment we require to achieve some of the reforms that we want, some of which you have been supportive of in the past—particularly automatic erasure for people who commit serious offences. On a wider issue going forward in 2015, we hope that following the May 2015 election, irrespective of the persuasion of the Government we have, the Law Commission Bill is taken forward. We and other regulators, and probably you, were disappointed that it was dropped from the Queen’s Speech. We would like to see the next Government give it priority. That would allow us to do what you, I think, and the public want us to do: to reform many of our legislative measures to take some of these things forward.

Thank you. We are happy to answer any questions on those points, or anything else you care to ask.

Chair: Thank you. That is very timely because it is a point that Andrew was going to come to.

Q3 Andrew George: On the last point you made, Professor Stephenson, on the Law Commission Bill, you say that it is important to the GMC, and indeed I think all the other regulators are indicating the same. You may have noticed that in fact I raised this with the Secretary of State the last time he was before us, just before Christmas, and asked whether there was, presumably in the remaining weeks, an opportunity for some housekeeping issues to be brought in and sorted out. He indicated that, if time allowed, we might look at this. Certainly I and others are very keen for that to happen. If we are able to do this, why is it so important to the GMC that the Law Commission Bill is brought forward—the regulatory reforms? What are you unable to do now that you would be able to do, which would improve your fulfilling your role?

Professor Stephenson: The reason we have the section 60 amendment going through is that we have to amend the Medical Act each time we want to do something. Professional regulation is a constantly changing system and the first thing the Law Commission Bill would allow us to do is to be much more fleet of foot as things change in the future, without constantly having to come back to Parliament and trying to find parliamentary time for section 60 amendments. The second thing is that it would reassure the public, in that they probably find it strange that the nine health professional regulators each have different processes. To have a single regulatory framework, a single legal framework, which all of us were working under, would make sense to the public. I do not know whether His Honour David Pearl would like to add anything, or Niall.

His Honour David Pearl: Only to say that, as Professor Stephenson just mentioned, at the moment whenever we feel there should be a change—even a relatively minor change—we have to go through the section 60 procedures. That takes upwards of two to three years for changes. That is the main reason why, from my perspective—from the MPTS—we want to introduce changes much more rapidly. Case management is a particular concern of mine, as I think this Committee is aware. We cannot make major changes in case management to have more effective adjudication without an amendment to the Medical Act that the Law Commission Bill would provide for us.

Q4 Andrew George: I presume that there are no downsides, from your point of view, to the introduction of the Law Commission Bill. Given that you, and indeed all the other regulators, are keen for it to proceed, what discussions have you had with the Department to find legislative time and to emphasise the importance of getting it through?

Niall Dickson: It is only the first part. Broadly speaking, we are very much in favour. That means we will have, of course, to look at the detail of the Bill as it emerges from its next set of iterations, which at the moment is the Department of Health going through the draft Bill and amending it. We are in discussions with the Department about various aspects of that, and obviously we will want to ensure that the powers of the Secretary of State are not too great in relation to this and, of course, that accountability to Parliament—this is

something we have gone on about, and not just in front of you—is very much built into the framework.

As far as the process is concerned, we lobbied, as indeed many of you did helpfully, unsuccessfully to try to get this into the last session of Parliament. The current Administration is very much of the view that it is an important piece of work and they have, to be fair, lots of civil servants working on it. They have not just sidelined it, forgetting about it; they are genuinely working on it.

The hope is that, when a new Government comes in, this will be something that can be relatively easily taken from the shelf, something that could be relatively uncontroversial, though not without its difficulties, that could be brought in the first session of Parliament. But, of course, that will depend on what new Ministers wish to do. We would be very concerned if there were any delay, and certainly if it was not in the second session we would be extremely worried. Some of our fellow regulators would be even more anxious about it, because, arguably, they have suffered more than we have at not getting access to section 60s, so their framework is even more outdated than ours.

Q5 Andrew George: Finally, are there any aspects of your new corporate strategy that you would find challenging to deliver without the Law Commission Bill being enacted?

Niall Dickson: Yes. The national licence exam, which Terence mentioned, would require that; any change in the register would require that; our commitment to speed up our fitness to practise processes, not least using consensual disposal where we are able to agree with the doctor the outcome without the need for referral to a panel, would require legislation; so, too, would our demand that we are able to get rid of doctors who have committed rape and serious criminal offences without the need to send to a panel. All those things can only be done if we have a series of section 60s, which there is not a prospect of, or if we have fundamental change. It is time for fundamental change, in our view.

Andrew George: That is very helpful, thank you.

Q6 Barbara Keeley: When you are considering your future strategy and regulatory approach, how do you avoid creating an environment whereby doctors practise defensive medicine to avoid being subject to complaints and investigation?

Professor Stephenson: As a practising doctor myself, I can vouch for the fact that all professionals, to some extent, fear regulators; it is always in your mind from the time you are a student onwards, but it is a healthy respect. There is a narrow dividing line between, as you say, practising defensive medicine.

My own experience is that medicine has become more defensive over my practising lifetime. I think that is driven more by fear of litigation than fear of being reported to the regulator, personally. But my sense is that medicine has become more defensive. I do not hear colleagues saying, “I am doing this test or investigation because I am worried I will be reported to the GMC.” I certainly hear that people feel conscious that their practice can be vilified in the press, they can be reported to a lawyer and they can be complained

against to their trust. They are very aware of different things bearing down on them, but personally I do not see the GMC as being any more than those other three.

Q7 Barbara Keeley: No, but is there anything in your strategy or approach that could help mitigate that, if you like, given that you are saying that you accept the tendency to fear litigation or to fear being complained about is there and has worsened and that there are so many routes for doing it? Given the role of the GMC, can you do anything to help to mitigate it?

Professor Stephenson: Yes. There are things in our strategy that help doctors deal with the fact that they are under GMC procedures, though I am not sure they make a difference to the defensive practice of medicine. For example, for people under procedures we have a service run by the BMA—very deliberately outside the GMC—to help people going through procedures, to provide counselling and support.

We have a very strong principle of innocent until proven guilty. We are looking at anyone who has health problems having a senior medical person within the GMC oversee the case. We have a helpline that people can call and, although it is not in our remit, we have been supportive of the practitioner programme—a medical service for doctors who have particular problems with mental health problems, drug dependency and so forth. Those would help doctors going through the procedures. I am not sure, if you were a practising doctor who is not under any procedure, that they would make you less likely to practise defensive medicine.

Niall Dickson: The additional point, I suppose, is that the traditional profile of the GMC—it is still the one, I guess, that most doctors think of—is in relation to fitness to practise, but, as you know, of course our responsibilities extend well beyond that. There is a tension between our need absolutely to protect patients around fitness to practise issues and also our need to engage in the education of doctors, that is to say to have a relationship with students and increasingly—it has been a big part of our work since 2010 when we took it on—our relationship with postgraduate doctors, doctors who are going through their training. To some extent—I do not know if Judith would concur with this analogy—we are not quite the knight in shining armour, as it were, but we certainly are the people who intervene to make sure that those doctors have the right environment and the right support going forward.

You asked about our strategy. We still have to do the fitness to practise work and it is really important, but in the longer term we want to have our relationship with the profession as a rather different one, not least because of revalidation. It is an ongoing relationship; it is not, “Hello, GMC. I’ve now got my card and I’ll see you when I die, and I’ll try and keep below the radar.” We need to have an ongoing relationship with you about professionalism, about how we drive up professional standards, about giving us the assurance that you are competent and fit to practise. That makes the relationship between regulator and registrant different, and we are only at the early stages of starting to develop that.

The impact of postgraduate education, which we inherited a few months after I came to the GMC, has been more profound to us as an organisation than we anticipated. It has

been beneficial for us, but I hope we have also made a real difference in postgraduate education.

Q8 Barbara Keeley: Perhaps Judith can answer this point, too. Should young graduates entering the profession accept that they may be investigated, that things have progressed to the point whereby they must accept it as something they may well have to deal with? As part of developing emotional resilience, you have to see that this is a possibility.

Dr Hulf: Yes, there is an element of that. Reflecting on what Niall just said, we have made substantial progress over the last three or four years in communicating with doctors. Certainly from my own perspective, when I was in clinical practice, I am not at all certain that doctors quite understood the range of functions of the GMC—probably many still don't. Undoubtedly the advent of postgraduate medical education in the organisation, under its regulation, has made a huge difference, because all the visiting to trainers, trainees and health care institutions is now part of the GMC's organisation.

Another thing that has happened in the last two years is the development of our regional liaison service, which is a very outward-facing service. I know from the feedback that has been given on the work of this group that many doctors know things about the GMC now that they never knew—even very senior doctors. There is the ability to communicate with the GMC. They may not want to see us every day of their lives, but they understand that we are there to protect patients, and that we are there to protect patients by upholding the standards of our profession. That is our link with doctors. Does it make them more defensive? Should we be encouraging medical students to be more defensive? We should be encouraging medical students to be very conscious of all the safety strategies that they need to learn, but to know that they have a robust regulator who will defend their professional standards and work. That would be the way that I would see us communicating.

Q9 Barbara Keeley: The question was, in those contacts with postgraduates, the people you are in contact with, should it be broached that it may be part of their career that they will at some point be complained about, and that they need to see that as normal and not something that causes stress, mental health problems or all the other things you touched on?

Professor Stephenson: I have personally been investigated twice by the GMC. Doctors recognise having complaints against them as an occupational hazard; if you have a career of 30 years, seeing 25,000 or 30,000 patients, it happens. Your comment about resilience training is very well taken. I am struck by how much the military invest in resilience training, and from talking to them I gather they do not wait until they are out in Helmand province; they start at recruitment and training. That is probably something we could think about exploring. I think what you are getting at is building in resilience training when people are medical students and young trainees rather than waiting, perhaps as in my case, until you have been reported or had a complaint and then trying to develop that resilience. That point is well made.

Chair: Thank you. That takes us on to David.

Q10 David Tredinnick: I want to ask some questions about understanding the growth in complaints, but before I do can I go back to something Judith said—that doctors do not understand the range of functions at the GMC? I am slightly surprised to hear that. Surely you can put that right with a leaflet, can't you?

Dr Hulf: Yes, you can, but—

David Tredinnick: What you said is astonishing, really.

Dr Hulf: But everybody has to read and understand the leaflet. It has to be ongoing education. We have to talk to doctors face to face, and indeed we are doing so; we have been beginning to do that much more over the last two or three years. That is much more compelling than receiving a leaflet through the post.

Q11 David Tredinnick: That is all very fine, but, Professor Stephenson, you set out in your opening statement what you thought the improvements should be. You covered the areas very clearly—I think there were four of them—and I cannot believe it is beyond doctors to have a basic grasp of that. Indeed, your Honour, ignorance of the law is no defence. Is that not right?

His Honour David Pearl: In this context, are you saying?

Q12 David Tredinnick: I just think it is very strange that doctors could be in the situation that they do not understand the range and functions of the General Medical Council.

Niall Dickson: Our range of functions has changed, so a lot of doctors will have had ideas when they were doing their undergraduate training and then, of course, they will have had various communications from us; it is not for want of trying to communicate, I assure you. I think there are more effective ways of communication, a bit like Judith has mentioned.

Last year, our regional teams met more than 15,000 doctors face to face. That is a very old-fashioned way of communicating; it is quite intensive, but it is the way you get an impact. The vast majority of those doctors, after their interaction with the GMC, said they would change their practice as a result. Having that communication is an important element in how we continue to try to make doctors understand what it is we do and why we do it. But it is a “paint the Forth bridge” business; you have to keep going at it.

Q13 David Tredinnick: Do you have a GMC app? Can you pick up an iPhone, hit a button and go into GMC?

Professor Stephenson: You can go to the GMC website, which will tell you about all of the things we have been discussing. It is all in the public domain.

David Tredinnick: Thank you very much.

Niall Dickson: We are also developing a series of apps, particularly around postgraduate education and in the education world, as to our standards. One of the challenges we have faced in recent years has been that, although we produce what are, I think, widely

recognised as very good professional standards, are doctors reading them and how relevant do they find them in practice?

Q14 David Tredinnick: The impression you give is a rather old-fashioned communication service where doctors do not even get leaflets that they could read to understand the basics of the GMC and that you are not right up there with the high-tech.

Valerie Vaz: I actually got these leaflets from the GMC. I am surprised you have not. There are lots of booklets that come out.

David Tredinnick: Anyway, we had better move on or the Chair will call me to order.

On understanding the growth in complaints, in your evidence you state that locum doctors are among the group that is more likely to be complained about. Does the nature of locum work mean that these doctors are more at risk of making errors that can result in an investigation?

Professor Stephenson: Almost certainly. When you practise as a locum, you turn up in a practice or a hospital where you have not been working before; you will have a very short induction and are perhaps being employed to cover one shift for one night. I can understand easily why a locum in any walk of life would find it more difficult to work within a system they are unfamiliar with, and therefore complaints would be more likely.

Q15 David Tredinnick: I need to explore the issue of foreign doctors. Are foreign doctors working in the UK more likely to be employed as locums than British graduates?

Professor Stephenson: That is not something I have data on. I am sure we could get back to you. I am not aware of a split between overseas doctors and UK graduates.

Q16 David Tredinnick: It is logical, is it not, that if you have a shortage and you are filling it from abroad that it will be filled by foreign doctors.

Professor Stephenson: There are quite a lot of UK doctors who also do locum work—very common.

Q17 David Tredinnick: Is it not proportionately more likely that they will be foreign doctors?

Professor Stephenson: We can write to you with the information.

Q18 David Tredinnick: Among UK graduates, black and minority ethnic doctors are more likely to be investigated or sanctioned than white British doctors. Since we last held an accountability hearing, what have you done to try to understand why this is?

Professor Stephenson: That is a very fair question. Perhaps I can put it in context, and then ask Niall and David whether they want to comment further. To lump BME doctors as

one is not so helpful. That includes doctors who qualified overseas, who, as we were just describing with locums, come to another country, culture and language and a different health service. Therefore, it is more likely, just as if I were to go and practise in another country, that they are going to encounter problems and have complaints against them.

Of greater concern to me are BME doctors who were born, educated and went to medical school in this country and are UK graduates. Within our data they have about a 30% greater chance of having a sanction against them than white UK graduates. That is a subject of great concern. It is clearly not something simple for the following two reasons. One is that BME UK graduates born in this country also do worse in all undergraduate and postgraduate exams, not just medicine; in every university subject in the United Kingdom they do systematically worse. We also know that they are over-represented among whistleblowers and complaints. We also know that if you look at regulators of other professions, like lawyers, UK BME lawyers are over-represented. There is a big issue here that the GMC is not going to duck. I personally feel passionately that this is something we need to look at very hard, but I cannot give you a simple answer about why it is.

Q19 David Tredinnick: You have just said that it is something that you need to look at, not that you are looking at. Surely if you believe sincerely this is a problem, it behoves you to have an active—proactive—campaign to make it easier for doctors from black and minority ethnic backgrounds to not fall foul of the system.

Professor Stephenson: Yes.

Q20 David Tredinnick: What is being done about it, please?

Niall Dickson: We have been extremely active and not least first of all—

Q21 David Tredinnick: Can you tell us how—what sort of action?

Niall Dickson: I am going to do that now. The first thing is understanding the nature of the problem; the difficulty of not seeing where the difference was between what was happening with BME UK and foreign graduates was a complicating factor, because the vast majority of foreign graduates, particularly before the rise of the EU arrivals, were from ethnic minorities. So it was quite difficult to work out whether what you were looking at—the point that Terence made—was people coming from other countries and therefore struggling within our system, or whether it was a race issue that was going on. The first point is that we have started to unpick that.

I think there is a difference between fitness to practise and education, and perhaps we can look at both of those. Terence mentioned the question of attainment. Attainment in medical school is replicated across higher education, so it is not necessarily something strange. Kids who are doing as well in their A-levels do not seem to do as well, from BME UK backgrounds, when they are in university. That applies to medical school as it does to other areas. There is quite a lot of literature on this. I am not saying the GMC will throw some magic light on it, but we certainly want to work very closely with medical schools around how one tackles it.

The second issue, which again applies more to international medical graduates than it does to BME UK, is that these doctors, when they come and sit postgraduate exams, do less well. This is applying across not just GPs, where there has been a lot of attention; we think it is applying across other specialties as well. We have a major programme at the moment, which Judith will no doubt expand on, where we are looking at understanding that differential in attainment, not just by race but by other reasons as well—why some doctors do not seem to do well, or not as well as others.

Then on the fitness to practise side, we have understood for the first time that there is a difference between referral and sanction. If you are BME UK, or indeed IMG, you are not more likely to be referred to the GMC by patients but you are more likely to be referred by employers. Again, we need to start understanding that. That affects the sanction, because doctors who are referred by employers are much more likely to get a severe sanction. There are good reasons for that, as well.

There is another difference, which is that the referrals for doctors, for IMG doctors—international medical graduates—tend to be around conduct and probity and are less likely to be around clinical performance. Clinical performance is something you can remediate, so it has less serious sanctions at the end of it.

I could not have told you any of that last year. We have dug around to try and understand this data. We do not fully understand it all, but we are beginning to understand some of it.

Dr Hulf: You asked what we are doing. We have referred to this discrepancy overall, because we want to include not just BME doctors but gender difference and so forth as differential attainment. The work that we are doing as far as education is concerned, we are not doing alone: we are doing it with the professional bodies and the medical royal colleges, looking at their examination data; we are doing it with the medical schools; we are doing it with the training authorities, HEE and the training authorities in the other three UK countries, looking at recruitment to success, at progression during postgraduate training and so forth. This is a very big and complex piece of work. We are nowhere near the end of it—we do not have any answers for you—but we have definitely begun to do it and we are expanding on it. We will not be able to do it alone; we will have to involve others.

His Honour David Pearl: On the adjudication side, there is a particular concern in relation to unrepresented doctors and also doctors who do not attend our hearings, especially the latter case. If a doctor does not attend a hearing, it is perhaps more likely that the panel will decide that the doctor has not remediated and not shown sufficient insight, and it is more likely the sanction will be more severe.

We have examined the doctors who do not attend and the doctors who attend but represent themselves, and it is common that those doctors fall into the category that Professor Stephenson has been talking about. We have been trying to help in this area. We have a number of pilots running in relation to unrepresented doctors in particular. We now have an arrangement with some of the local law schools in Manchester—the universities there—with telephone calls: if a doctor wants assistance, wants information, he or she can make a telephone call and will be given that information. We are trying to help the unrepresented doctor, and in this way I think we will be able to tackle some of the issues you have just identified.

Q22 David Tredinnick: Thank you. I have one last question relating to this. What steps have been taken by the General Medical Council and the Medical Practitioners Tribunal Service to proof the investigation and tribunal functions against bias that could be detrimental to foreign doctors and those from an ethnic minority background?

His Honour David Pearl: We have a quality assurance group, which I chair. The quality assurance group looks at the vast majority of our decisions—both the fitness to practise decisions and also the interim order decisions made by our panels. We are quality-assuring those decisions in relation both to the reasons why they reached a particular decision on the facts, on whether there has or has not been impairment, and on sanction. We are obviously quality-assuring that against bias as well.

Professor Stephenson: Can I place this discussion in a slightly wider context? About 40% of the 220,000 doctors on our register are BME doctors. They have been at the heart of supporting the NHS since its inception 65 years ago, and we are talking about relatively small numbers. It is quite right that we explore this and I feel passionate about it, if for no other reason than that; they have contributed hugely to the health service and continue to do so on a daily basis—it is important that we recognise that—often in unpopular specialties and in single-handed inner-city practices.

Q23 Valerie Vaz: I want to pick up on some of the questions that my colleague has very helpfully highlighted, to look at, if you can give figures, the doctors that are referred. Are they doctors in those difficult things like mental health or inner-city areas or are they consultants who are referred? Is it a question of there not being the mentoring type of facility that may be available to people from different backgrounds, including women?

Professor Stephenson: Paradoxically, in view of our discussion about resilience, the doctors who seem most likely to come under our procedures are older doctors, not younger doctors; they are men, not women; and there are some specialties that are higher risk than others. As we have already mentioned, international medical graduates, be they EU or former Commonwealth countries, are very over-represented; and BME doctors born in the UK are 30% higher. Those are the groups that particularly are over-represented in our complaints procedure.

Niall Dickson: We are trying to understand. Just building on that, we have only, again, relatively recently started to bore into this information. Traditionally, the GMC has mostly collected information for operational purposes not for analysis, so we have made considerable advances to try to understand all this stuff. One of the things that we established in our state of medical education and practice report was that there are points in a doctor's career where they may be more at risk, as well as the big things that Terence was just talking about. Shortly after somebody is made a consultant or a GP, there is a spike at that point. We cannot necessarily answer the question that that raises.

The other area—we have been more transparent this year than ever before—is that we started publishing where fitness to practise concerns are coming from geographically. We publish them in a very neutral way because we do not understand whether a hospital, for example, that sends lots of cases to us is very good at monitoring or whether it is demonstrating that they have a problem in practice. We do not know this stuff, but only by

starting to mine the data and by starting to be more transparent with it will we start to understand more.

One of our big objectives is to have a project which looks at the doctor's career, both at types of career and time wise—where in their career they may be at risk—and also looks at geography and specialty, about where there are higher levels of risk, so that we have better understanding, and the system itself has better understanding. That is not so that we can finger people, but you can actually support at various times to try to stop people being referred into your system.

Q24 Valerie Vaz: In terms of the mentoring point that I made—having someone like Sir Charles Sparrow, who sits there with his trainee next to him and then brings one person along, whereas on a broader basis, the rest of the doctors are not brought along and you have your favourites—how do we get round that? Are you aware of the study in King's College, in the medical school, where they took trainees, young people who maybe had not got their A-levels but by the time they had done the foundation course they were exactly the same as everybody else who got absolutely A-stars? Is that something that can be built on?

Dr Hulf: Yes. On your latter point, yes. Recently Niall and I visited a medical school where they had exactly that system. They had a parallel biomedical sciences course within the same city, and the students on that course knew that, if they did well enough in their first year, there were places at the medical school for them if that was what they wished to do. These were perhaps individuals who had not done particularly well at A-level, were perhaps from poor socio-economic backgrounds and they actually had the opportunity to study medicine. Once they were on the medical course, you are absolutely right; they were indistinguishable from the other students. That is not the only example, but we were able to see that in autumn last year. Those organisations are very compelling, and we would do our utmost to encourage the expansion of that sort of system.

Q25 Valerie Vaz: I have one last factual question on what my colleague raised about locums. I have written to you about the number of locums in the system and I do not think there is anyone in the NHS who can actually give me an answer—it is quite important in terms of accountability. Do locums have to go through revalidation?

Niall Dickson: Yes.

Q26 Valerie Vaz: How do they do that?

Niall Dickson: They are required to have a responsible officer who is working for a designated body in exactly the same way. There are differences between GP locums and those that are more peripatetic, if I can call them that—those who are moving round. One of the great gains that we see with revalidation is pulling locums into a governed system: they are required to provide the same evidence that any other doctor has; they have to bring the same evidence to appraisal; they have to have regular appraisal; and they must have the patient and colleague feedback that all other doctors are required to have. Some may find it more of a challenge, especially if they only spend two days in one place, but the argument we have always made is, “Well, fine, but the responsible officer should be

finding them somewhere to spend longer so that they can get that patient and colleague feedback.” It puts an onus also on organisations, because simply blaming the locums is not the answer.

The answer is organisations. I have come across even very good ones that say, “It wasn’t a very good locum so we just won’t have them back again.” There is no feedback given to the locum agency, and, as a result, that person keeps on going round the system. The new requirements of the NHS in England are that you must provide feedback on the locum who has come to you. The organisations running locum agencies will be much more demanding about saying, “We need to have that feedback,” because they are responsible now for the quality of the people they are sending into hospitals. Again, it is very early days in the process, but we think we are starting to get some traction in an area where previously, frankly, there was not.

Valerie Vaz: Thank you.

Q27 Chair: Professor Stephenson, you mentioned earlier that BME doctors who identify themselves as whistleblowers are over-represented in the group of doctors who have been complained about. Can I focus a bit more on the wider area of whistleblowers? Could you update us with progress on the Hooper review, which looks at vexatious complaints about whistleblowers? Where are we on that? I know you have commented that you do not want to release your report until after Francis has reported further in his “Speak up” review, but could you at least give us some progress and update on where we are in this area?

Professor Stephenson: The GMC have invited Sir Anthony Hooper QC, a former judge, to undertake a review of when the GMC comes in contact with people who might describe themselves as whistleblowers, and indeed to try to deal with the difficult issue of where one doctor reports someone to the GMC, effectively whistleblowing, and then someone else counter-whistleblows in a sense. We are very conscious that Robert Francis himself is conducting a similar review. We do not want them to get out of step, so Anthony Hooper is in consultation with Robert Francis, and his report will be published, hopefully early in the new year. I do not know whether you want to add anything, Niall.

Niall Dickson: It is exactly as you say. Anthony Hooper is anxious to see what Robert Francis says. They are not colluding, but they want to be in step, as it were. We would expect, as we understand it, the Francis report—we are not talking about the Mid Staffs sort of time scale—to come early this year, and we will publish shortly after the Francis report.

Q28 Chair: Clearly, there were very important issues with whistleblowers, so that is something you will be actively pursuing as soon as both reports are available.

Niall Dickson: Yes. There may be lessons for us from the Francis report. Obviously, the Hooper report will be very specific, and the recommendations for us will be something that we will take very seriously indeed, having commissioned the report.

Q29 Chair: Something for our successor Committee. Before we move off the area of the growth in complaints, could you clarify from your evidence that, after years of inexorable rise in complaints, they have now stabilised or slightly fallen off? Is that correct?

Niall Dickson: No. I am sorry it may have appeared that way.

Q30 Chair: It did come across that way in your evidence.

Niall Dickson: I will try to explain. It is to do with what we count. Historically, the GMC has counted things called inquiries. The vast majority of them were complaints about doctors, but they included various other things as well. The number of them has actually gone down, not because of the fitness to practise ones but because the extraneous not quite right ones, thankfully—partly because we have redone the way our forms are done and so on—are not coming through to us in the same number. If you simply look at the fitness to practise issues, I am afraid to say they have continued to go up, not by the same levels as they were when we were talking about 25% a year, but the last rise, the 2013 rise over 2012, is a 6% rise and I think you will find 2014 is, but we do not know the final figure.

Q31 Chair: It is 6% as opposed to previous levels.

Niall Dickson: Yes, it is still going up, and the base, obviously, keeps on growing. So between 2010 and 2013 we saw a 64% increase in complaints.

Q32 Chair: Between 2010 and 2013, a 64% rise.

Niall Dickson: Yes. Across those four years, a 64% increase in the complaints that we receive, which is very significant.

Chair: Thank you for clarifying that, because it was not altogether clear.

Q33 Valerie Vaz: Are those serious complaints? Are they stream 1, stream 2?

Niall Dickson: They are complaints, full stop, but we have also seen within that an increase in serious complaints as well. That sounds bad, in a way, but, on the other hand, if we are able to encourage the proportion of complaints to be the serious complaints, those are the ones we really should be dealing with and that are right for the GMC to deal with.

Q34 Chair: To clarify, over that wider time period, the increase in serious complaints would be how much—64% in total, but—

Niall Dickson: I will have to get back to you on the exact figure, but they have gone up, and we have, for example, in 2014, which is not in these figures, seen another quite significant rise in serious cases. They are the ones, of course, that take up huge resource, so we put an additional £2 million into our fitness to practise operation last year, to manage the serious stuff that was coming through.

Chair: Thank you.

Q35 Valerie Vaz: That leads quite helpfully to the time limit: you have about 12 months to look at a case. Could you highlight the pinch points and why it cannot come down slightly? Why is it taking so long? Is it resources, or lack of investigators or evidence?

Professor Stephenson: I said that 91% are dealt with within 12 months, so perhaps you are asking why there are 9% that take longer.

Q36 Valerie Vaz: Or if the 12 months could come down. What is causing it to take 12 months?

Professor Stephenson: A number of factors. One is that, as you will be aware, some of these issues are quite complex, but perhaps the most important one is that it is not entirely in the hands of the GMC. There are invariably at least two parties involved. The other party have lawyers, they may have a medical defence organisation and they will want time to prepare their case. The medical records have to be obtained from the hospital trust or from the employer. Each of those can in themselves introduce a delay over which the GMC has no control. It rather goes back to our opening discussion about section 60 and the Law Commission Bill.

We would like, and I am sure David would like, much tighter case management. Tight case management requires some threat and sanction, not just well-meaning terms. With tighter case management through the Law Commission Bill, we could get those times down, but at the moment, in fairness to the GMC—I am not saying we are beyond reproach, as I am sure we make mistakes and have delays as well—there are other organisations involved. Certainly if there is a police inquiry running, our whole process is put on hold while that police inquiry is continuing. If you look at the cases currently that are over three years, almost all of them have a police inquiry running.

Niall Dickson: For all those that missed the target, as it were—if you wanted 100% within 12 months—external lawyers looked at every single one. We are reviewing every single case: “Is there anything we can do to move this on? Is there some way it has got stuck in the system?” We are constantly doing that. We have introduced lean management techniques into the whole of our fitness to practise procedures to try to speed up every single stage of it that we possibly can. It will be speeded up if we can get consensual disposal. That is one way in which we can improve it.

We recently tried another way, which perhaps the doctors will recognise from the idea of putting a consultant in A and E right at the front—in other words, putting somebody more senior right at the start of the process to see whether we can deal with cases more quickly. We have taken our more senior decision makers and put them at the front of a serious investigation to see if there is one piece of information that we could get, to deal with this thing rather than have it chug through the system. We are constantly looking at ways in which we can try to speed the process up. On the other hand, these are doctors with their livelihood and they will have defence, they will have lawyers and there is a process; people will rightly demand that the evidence is there and thoroughly looked at.

Q37 Valerie Vaz: That is right, but we have had written evidence from doctors who have been through the process who say it takes a huge toll on them. Is there absolutely nothing in the way you organise your procedures that will enable you to shorten that waiting time? It may be someone saying, “We will do this within six weeks and exchange of documents within six weeks after that.” Is there nothing that you can do?

His Honour David Pearl: I can again only talk about what happens once the case has been referred by the GMC investigation team to the MPTS. When it is transferred to the MPTS we also have a service target, and that service target we always meet, which is to have the case heard in the tribunal within six months of the case being referred by the GMC to the MPTS. We do that in at least 90% of all those cases. It goes back again to case management. If we had the powers to say to both the GMC and the doctor’s representative, “Documents need to be disclosed and expert witnesses need to have their witness statements produced by a certain date. If you do not meet that date then maybe that evidence will not be available to the panel or maybe there will be a cost implication if you do not produce it,” then we would be moving closer to the way in which the Courts and Tribunals Service operates outside the regulatory functions.

Valerie Vaz: Thank you.

Q38 Grahame M. Morris: Professor Stephenson, you may have answered this a little earlier, but in relation to questions about the length of investigations, you indicated that over 90% are dealt with within the Committee’s recommendations from last year, within 12 months. You were talking about resilience training and learning some lessons from the military.

In relation to Sarndrah Horsfall’s review and her recommendation that doctors should feel that they are treated as being innocent until the outcome of the case is known, where are the GMC going with that? Are you taking that on board? Are you implementing it? I have a particular case in my own constituency of a really eminent GP who is under enormous strain and incredibly popular locally and, though the case is perhaps a very complicated one, it is dragging out. Is there some merit in what the review is recommending?

Professor Stephenson: When I was on the GMC council between 2008 and 2012 I was very struck by the sense, as we discussed earlier, of feeling guilty until proven innocent and feeling that there was a smoking gun. While I was on council I encouraged the GMC to undertake, and the GMC did undertake, a complete review of all the letters and the documents that it sends out, or sent out then, to try to make them less brusque and intimidating. But at the end of the day, I was also advised by lawyers—I am not a lawyer—that this is a quasi-judicial proceeding, it has a legal framework, and there are statements and phrases that have to be in those letters that terrify people like me. When that letter lands on your doorstep and you open it, it is pretty intimidating stuff, but there is a legalistic element to that. I think we are minded to look at that again.

Q39 Grahame M. Morris: But is not the general principle of British law—I am not a lawyer—that you are innocent until proven guilty?

Professor Stephenson: The GMC is absolutely signed up to the principle of innocent until proven guilty. What I am saying is that sometimes our communication, because of its

legalistic nature, creates an impression that we do not stand by that, but we absolutely do. We absolutely believe that people are innocent until proven guilty. *[Interruption.]*

Chair: I am sorry to interrupt proceedings, but there is a Division in the House, so we will adjourn for 10 or 15 minutes while we vote. We will be back shortly.

Sitting suspended for a Division in the House.

On resuming—

Q40 Chair: Let us start by talking further about the Sarndrah Horsfall review. It is an area that has caused considerable concern among doctors. The review identified that there had been 114 deaths but 28 confirmed suicides during the period. Could you clarify—because there has been some concern expressed to the Committee from doctors—how many of the 114 other deaths might have been suicides which were not identified because of under-reporting through the coroners' system? Is that something that was considered in the review?

Niall Dickson: We will have to come back to you on that. I am not sure I am entirely clear about the question.

Q41 Chair: There were 28 confirmed suicides.

Niall Dickson: Yes, of doctors.

Q42 Chair: But there were also 114 other deaths of doctors during the period of the review. How many of those 114 that are not recorded as suicides might have been suicides? We know that suicide is relatively under-reported, so that was an issue that was raised.

Niall Dickson: A small number of doctors may have been suspected suicides but the vast majority of the others were, as far as we know, not suicides. We did not have any evidence that any of those doctors had committed suicide.

Q43 Chair: Was the background rate of deaths among doctors the expected rate that we would expect from a comparable group of people of that age?

Niall Dickson: We have looked at that. The answer is that the rate of suicide among doctors is slightly lower than that of the rest of the population, on the most recent figures. If you compared a period of time running up to now for doctors who died within the GMC procedures with the wider population of doctors who commit suicide—I do not have the exact figure—around 19 would be in our procedures and about 120 had committed suicide, as it were, not in our procedures, or not that we were aware of.

Q44 Chair: Was it a comparable rate, though? Was there a higher rate among doctors undergoing investigation than there was among the group of doctors who were not undergoing investigation, in other words?

Niall Dickson: Almost certainly, because the doctors who are under investigation come into investigation because they are already suffering severe depression; they have very serious mental health problems. Absolutely, it would be higher if you took the population of doctors who are in our procedures and the rate of suicide among them compared with the wider doctor population. But it is also true that there is a much larger number of doctors outside, who commit suicide who do not come into our procedures.

Q45 Chair: Of course, but you have already stated that over-represented among the group of doctors about whom there are complaints are older doctors and men, and of course they are over-represented among those who are at risk of suicide anyway. I was asking whether if you compare a similar demographic of doctors who are not under investigation—that is, mostly older male doctors—are you seeing a higher rate of doctors taking their own lives during the fitness to practise proceedings?

Niall Dickson: I am absolutely sure—we can get the exact figures, but I do not think we have done that comparison and I do not think the report did that comparison—that the rate of suicide among doctors who are in our procedures is bound to be higher for the reason I have described.

Q46 Chair: Indeed. We can see that might be a logical conclusion, but was the statistical analysis done? This is a very sensitive area obviously for doctors, and when I ask people what they would like me to ask the GMC, this is the most common question asked by doctors, who are very concerned about this. It would be reasonable to be able to say, “Compared with the background demographic, are we over-represented?” In other words, is there more that the GMC could or should be doing to support doctors through what is undoubtedly a very stressful procedure? No one doubts that you need to get the balance right and your primary role is to protect the public, but this is an issue of importance to doctors who have contacted the Committee.

Niall Dickson: We absolutely will do that and we will provide you with the exact figure. The reason we commissioned this review was partly that we do a significant event review every time a doctor commits suicide, and we were concerned that each time we did a significant event review we could not identify anything that we could have done differently. That is why we commissioned this independent look at it: are there things that we can do, recognising that this population of doctors is extremely vulnerable when they come into our system? We obviously could be the straw that breaks the camel’s back, as it were, but anybody coming to our procedures, as we have described before, will find it traumatic.

These doctors are coming into our procedures often having lost their job and their family life; they are mentally in a really difficult place, and it is inevitable that coming to the GMC can be an additional stress. That said, there are also doctors, and indeed those looking after them, who have said, “The referral to the GMC was the one thing that saved my life because at last I had to face up to what was previously an ongoing and deteriorating situation.” We would like many more of those stories, and we want to try—that is what the report is about—to make sure in every way we can that whatever we do does not exacerbate the situation, and yet continues to protect the public.

Q47 Chair: Yes, and of course the public would expect the GMC to continue to take a very hard line on doctors who are abusing substances and alcohol, particularly at work. Presumably it would always be your priority to protect patients in that situation.

Niall Dickson: Absolutely.

Q48 Valerie Vaz: Let us move to a similar kind of area about the tribunals. You have come before us a few times in your accountability hearings and you have asked for a right of appeal from the MPTS. First, why do you think you need it? Secondly, what do you say to the Professional Standards Authority who thinks that you do not need it?

Professor Stephenson: I will take the first one and let Niall take the second. The reason we need it is, as Dr Wollaston said, that our primary purpose is to protect the public. If we have referred someone to the tribunal service and we think that the sanction against them does not adequately protect the safety of patients and the public, it is right that the GMC should be able to appeal an inappropriately generous finding. As to the Professional Standards Association, I guess you would need to ask them about their thinking, but our sense is that they have been very supportive of us in the past.

Niall Dickson: You have to ask the PSA for some clarity on this. Our understanding is that the PSA supports our right of appeal, and that, like us, it recognises that it should continue to have its right of appeal should the GMC ever fail to exercise our right of appeal appropriately, or indeed if it is a case of under-prosecution by the GMC. Those seem perfectly legitimate objections.

A prosecutory authority, if I can use that term, having a right of appeal is not an abnormal thing at all. It is not a question of us appealing against ourselves. We have demonstrated, even before the statutory change that is about to occur with the right of appeal, that the MPTS is capable of making autonomous decisions, and that it is independently run. It recruits, the standards that it sets are all done by David and his team, and there is a genuine separation of function, which makes it legitimate, and indeed important for the MPTS itself, that the GMC is seen as something separate.

If you ask people who appear before the MPTS, whether it is lawyers, doctors or anyone else, they absolutely recognise that it is not like appearing before the GMC. It is something different—it is the MPTS—and the MPTS will be as harsh on the GMC as it will be on defence counsel, for example, who are not behaving as they should.

His Honour David Pearl: Certainly, from the perspective of the MPTS, the right of appeal is something that personally I would support, and the MPTS advisory committee that I chair would support it as well, because it underlines the independence of the MPTS. It is not a unique concept; it happens in the tribunals world generally, where either side, if it is unhappy with the decision, has a statutory right of appeal, and should exercise that.

Q49 Valerie Vaz: I would say, I suppose, in response—putting the other side of it, from what I have heard from you—that you have this independent tribunal that has made a

decision and it is almost that you do not like that decision so you have a right of appeal. But what about the other side? Do they get the right of appeal?

Niall Dickson: Yes, they do.

Q50 Valerie Vaz: What about the costs? Presumably we are talking about appealing to the High Court, are we?

Niall Dickson: Yes.

Q51 Valerie Vaz: So costs and time are escalating.

Niall Dickson: Costs can be awarded by the High Court to either side.

Q52 Valerie Vaz: That is what I am saying: costs are escalating. To take a case, if you are a doctor trying to defend your livelihood against what you are asking for, costs will also increase—for both sides.

Niall Dickson: There is a right of appeal by the PSA at the moment. Of course, if we lose and we take the doctor to the High Court, obviously the court will award the costs for the doctor's defence organisation.

Q53 Valerie Vaz: Yes, but I am trying to tease out why you need it, and our evidence is—what they say is—that you could just refer it to them and they will look at it again and make a decision on that. But are you talking about sanction, or are you talking about process? If you are just talking about sanction, presumably there could be something that you could filter into the procedure where, for example, you make an application to the MPTS: you do not like their decision, so you make an application and you say, “Please review this sanction because I do not think it is strong enough.” I am not quite clear what you want the right of appeal for? Is it a sanction?

Niall Dickson: Our appeal might be against the finding or the lack of finding, or it might be against the sanction which the tribunal—as it will in future be called—decides, and the High Court is the place that we go, as David says, when either side disagrees. The doctor can do exactly the same. The other thing that has changed is that this right of appeal, which has been written into the section 60, is slightly more robust than the current one. That is another important element in trying to make sure that we—

His Honour David Pearl: Could I help perhaps? I have read the PSA's evidence, which they presented to this Committee. They have a particular concern in one respect where they would still be exercising their right of referral under section 29, as it is, to the High Court. That is in what I would call under-prosecution, on which the GMC obviously would have no say. Let us take a case where the GMC bring a matter to the MPTS on a number of allegations, as a result of which the MPTS throw the case out, in effect, or impose a relatively low sanction—a condition rather than suspension or erasure.

The PSA will be looking at that case, as they do. They may think that the reason why the MPTS reached the decision it did was what they would call under-prosecution—in other

words, that the GMC should have investigated further and should have charged the particular doctor with more serious matters. The PSA will still have the power to take that matter to the High Court, and they do from time to time.

Q54 Valerie Vaz: Right, so why do you need a separate one? You talk about trying to work with doctors and having consensual sanction, or whatever—reaching a consensual conclusion—and we are trying to speed up this process, so I am wondering why you want to add an extra layer. I understand the legal side about having a right of appeal on both sides, but it seems to me that there is a way that you can have a case reviewed by the PSA. I am trying to filter out what exactly you need that is extra special, over and above what you already have from an independent tribunal.

Niall Dickson: As a prosecutory authority, where we think the decision does not protect the public, we want to have a right of appeal against a tribunal decision with which we do not agree. It is as simple as that. I think the other body's role is not to do that, but it is when we have not done our job, a bit like David said, and I do not see it as an extra layer; it is just a different route. This is not double jeopardy, as I think has been suggested. There is no double jeopardy. There is only one appeal, and the answer is that, if the panel has made a flawed decision or a flawed sanction, there should be a reasonable right for the organisation that brought the case to take it to a higher level of legal authority to ensure that patients are protected.

Q55 Valerie Vaz: It is, absolutely, and I agree with you, but I wondered if there was another procedure—for example, making an application. Could you give us an example of where you felt—I know the tribunal is very young and it has done some good work so far—that you needed that right of appeal, without naming names?

Niall Dickson: There are cases, though I do not think it would necessarily be appropriate to do this now, where David and his quality assurance team would also recognise that panels or tribunals are not perfect and they do make decisions. We can give you chapter and verse on it in one sense, because in every single case we call for a sanction. We say what we think should happen.

We are not always successful in persuading the panel that what we think is right. In some of those cases, I am sure the panel was right—they have sat and listened to all the evidence and so on—but in others we do not think they are right. We have discussions where we are, on both sides, trying to learn about how well we are prosecuting cases, if I can use that term, and obviously the tribunals reflect as well.

Valerie Vaz: Thank you.

Chair: That is perfect timing. We are now on Andrew George's questions on consensual disposal of fitness to practise cases.

Q56 Andrew George: Thank you very much—yes, perfect timing, as you say. I apologise for my late re-arrival at the Committee. We were talking in the earlier exchanges about consensual disposal of cases. The Committee concluded in our last report that

co-operating with consensual disposal of a case is not evidence in itself that a doctor understands that they have in any way failed. What are you doing to address the concern that some doctors may agree to sanctions without ever developing proper insight, as you describe it, into their own practice, where those failings are occurring?

Niall Dickson: We absolutely recognise this as an issue. It is probably true, I guess, in lots of judicial systems that people say whatever they think will get them a lighter outcome. There are two aspects to this. One is that a doctor simply saying, “Yes, I admit I made a mistake and I am very contrite,” is not itself evidence of insight. In terms of insight, we would be looking for any action that that doctor had taken to remediate or make better the situation and, going forward, that they have taken the necessary steps to ensure that their practice is brought up to the appropriate level.

In addition, we recently consulted on the question of apology and where it fits in this process. Certainly our view is that if a doctor gets to the consensual disposal stage—but it equally applies in front of panels as well—and says, “Well, yes, I am very contrite,” and whatever, but has not bothered or has not chosen to apologise to the patient, that is absolutely something that the panel or the decision maker at the consensual disposal stage would want to take into account. Making an apology is absolutely part of our guidance.

When doctors make mistakes, the guidance is absolutely clear that they must be open and frank about the mistake that has been made that has harmed patients and they should apologise for the error. Bringing that into our fitness to practise system, which it has not been in the past, is an important reform, making sure—your point—that insight is not simply going through a few legal hoops trying to get yourself out of the process. It has to be genuine, it has to be reflected in the practice and we would certainly want to see, if a patient had been harmed, an appropriate apology.

Q57 Andrew George: It looks like we are going to be interrupted again, but, because these are short questions, hopefully we might get to the end of this one. On the basis of the requirement to apologise, you say it is within the guidance but of course it becomes a punitive action, a requirement of the GMC. This is something which I know the Medical Protection Society has criticised; you are using the word “genuine”, but how do you judge what is a genuine rather than an insincere apology, and is that not just papering over the cracks rather than dealing with the substance of the problem?

Niall Dickson: There is a distinction to be made, and I will get David to respond as well. For example, a panel saying, or indeed at the consensual disposal stage somebody saying, “I require you to apologise,” was something we consulted on. That may not be the route we go down. As I said, we will have to assess what all the responses are and so on. We have had a huge response to this system, but you could have a system which had a requirement in the sense that when people are making a judgment about what should happen they should be looking at, “Has an apology been made?” and “When was the apology made?”, rather than an order, “You will apologise.” That might be another way. We have consulted on those. We do not want to pre-judge the outcome, but that is certainly one of the issues.

His Honour David Pearl: Very briefly, we consulted on apologies, among other matters, in our consultation on indicative sanctions guidance and we are going to be reporting, probably within the next month, on the response. We had an overwhelming response on all

the issues that we asked about. I do not have the figures in front of me, but it was really a very large number of people who responded. It is true to say that the idea that an apology would be, if you like, imposed on a doctor is not one that we would wish to pursue.

Q58 Andrew George: On the other hand, you have the power to erase doctors without a fitness to practise hearing. That gives the impression that things can be resolved behind closed doors. Do you not think that might give an impression that things are being stitched up by the GMC without proper public scrutiny?

Professor Stephenson: One of the reasons we would like the reforms we have been talking about is to have the capacity to make voluntary erasure when you are retiring quite separate from voluntary erasure when the GMC says, “We think you should come off the register,” and you say, “Yes, I agree, I have done wrong; I should come off.” We would like to make, again without the legal powers we have been asking for, which we hope you will help us with—

Q59 Andrew George: This comes back to the Law Commission.

Professor Stephenson: Yes. Your point is very well taken. We would like to be able to make the distinction very clearly that this is voluntary erasure not just because you want to stop working but because we require it of you.

Chair: Thank you. *[Interruption.]* I am very sorry, but we have to break for another Division. We will be back as soon as we can. Thank you.

Sitting suspended for a Division in the House.

On resuming—

Q60 Chair: As we are quorate, we will kick off again. I have a technical question about the registering of new medical faculties. What is the GMC’s view of formally recognising a faculty for forensic and legal medicine, given the complexities there are for doctors who are looking after vulnerable patients in custody centres, and that this is now going to be gradually transferred into the NHS? Could you explain the technical arrangements about formally recognising faculties, and whether you would look sympathetically at this request? I understand that in Europe that is happening. Perhaps you could update the Committee.

Dr Hulf: Yes. It is not a question of recognising the faculty; that is beyond our remit. Indeed, there is a Faculty of Forensic and Legal Medicine.

Q61 Chair: Yes, but it is about the doctors with a specialty within that.

Dr Hulf: Yes. It is a problem of recognising the specialty, and we are limited by European law in that there are to be no new specialties. Having said that, Europe—indeed our own Government—are supporting the introduction of aviation medicine as a new specialty, but

forensic and legal medicine have long wanted to be a CCT specialty, and it is certainly not the GMC that is preventing that. It is Europe that is preventing that, because it is introducing a new stand-alone specialty. My knowledge of European law is not extensive, but that is the blockage.

Q62 Chair: Am I right in understanding that this is happening in Europe, that there is a move towards recognising forensic and legal medicine, or is that incorrect?

Dr Hulf: I have not heard that, but you may be correct. The Faculty of Forensic and Legal Medicine have been part of our credentialing working group over the whole time—indeed, we used them as one of our pilot specialties to look at how we might assist them in the future. Again, we would need a change in the law to approve credentials, and indeed award credentials, as opposed to a certificate of completion of training.

Q63 Chair: That, again, would be helped if we moved forward with the Law Commission legislation.

Dr Hulf: It would indeed.

Q64 Chair: It would give you the flexibility to do that.

Dr Hulf: Yes, but it would not give the faculty of legal medicine what they actually want, which is to become a CCT specialty. That we cannot do without either a change in European law or Europe approving that.

Q65 Chair: Is that something that you would work with the faculty on to see where the blockages are?

Dr Hulf: We would absolutely support the faculty, and we have had a lot of discussions with them during our credentialing working group, and they know that. But a credential is not really what they want; they want a CCT, and that is beyond our remit.

Q66 Chair: Thank you for clarifying that. Another area of interest at the moment is Lord Saatchi's proposed Medical Innovation Bill. A number of concerns have been expressed from various quarters about whether the Bill is necessary and whether it would have unintended consequences resulting in potential harm to patients. Some people have argued that we need the GMC to issue clearer guidance to doctors around the limits on when they can innovate and use unlicensed medicines. Is it your view that this should be a matter for the GMC and regulators, or do you feel that stand-alone legislation is necessary?

Professor Stephenson: One of the things the profession is struggling with on this Bill is the problem that it purports to solve. We have just had published in December the research excellence framework that looks at all the research done by UK universities over the last five years. In that report, UK biomedicine and UK medicine did extraordinarily well and probably punch above their weight; the quality and output of research per pound or per dollar probably even eclipses the United States'.

This is a country that has pioneered gene research, monoclonal antibodies, many new drugs and many new cancer treatments. I am a researcher, an academic; I have been researching throughout my career. Many of us are struggling to see that we would be inhibited in our research by fear of litigation. That is also what the Medical Protection Society and the Medical Defence Union say; they do not have records of cases of doctors being sued because of being inhibited from doing research or doing new things. The UK leads the way in high-quality biomedical research. It has a record that it should be justly proud of, so we are struggling a bit to see why the Bill is necessary.

Q67 Chair: So the GMC is opposed to the Bill.

Professor Stephenson: The GMC is waiting to see. There are a number of organisations in the public domain who are quite clearly opposed to the Bill—I was chair of the Academy of Medical Royal Colleges and this is in the public domain, so I am not saying anything new—the Academy of Medical Sciences, the Wellcome Trust and the Medical Research Council. The GMC’s position, up to now, has been that it needs to see the final draft of the Bill. It has undergone a huge number of amendments and the devil is in the detail. The GMC reserves judgment until it sees the final version.

Niall Dickson: Just to expand on that, we absolutely, first of all, come at this from, “Why is this Bill necessary?” We still have not heard a convincing argument about why. We had very serious concerns about some of the clauses inserted as so-called safeguards. For example, having to go to a responsible officer beforehand would seem to us absolutely counterproductive, in terms of both putting responsible officers in an impossible position and also being an inhibitor for innovation rather than something that would enhance it.

So we were pleased when it seemed to indicate from Lord Saatchi’s amendments that they were going to drop those clauses. We still have concerns that the Bill, as currently drafted, talks about a doctor having another qualified doctor being enough for them to innovate. Our guidance is clear around people looking at expert opinion, people who are expert in that area and using that, of course, as one of the means by which you decide whether a particular treatment is to be taken forward. As Terence said, our position at the moment is, “Let’s see the next iteration of the Bill.” We still have concerns and there is still a question mark over the big picture, as it were: what is it trying to do? I suppose, in response to the final comment in your introduction, that if there is anything the GMC could do that would be helpful in terms of guidance, clarifying guidance or whatever, we would be absolutely happy to consider it.

Chair: Thank you. Can I come now to Virendra?

Q68 Mr Sharma: Thank you, Chair. The King’s Fund assessment of revalidation highlighted the fact that designated organisations had placed a great deal of emphasis on implementing processes and ensuring compliance. When will the emphasis shift from strict adherence to new regulations to making sure that the system achieves its fundamental objectives?

Professor Stephenson: That is a very fair question. To put it in a broad context, in my opening remarks I said that I had gone through revalidation, as has Dr Hulf, and, by

nature, it has to start as a process that you go through. The upsides I have seen of that at close quarters are people taking appraisal much more seriously; people who have never had appraisal in the past, which I think is appalling, being brought into the fold; and people being very cognisant of the kind of feedback that their colleagues and patients give. I do not see any of that as box-ticking. It is a process, but it is a process with a purpose.

In addition, the GMC has commissioned, and put in resources to have, a review of the impact of revalidation, conducted by independently commissioned research from the Peninsula medical school, so it is being done outside the GMC and will be an independent review. It will be some time, a couple of years, before that reports. We have given you the figures for the increased levels of appraisal in both England and Scotland; I do not have the figures for Wales and Northern Ireland.

It is early days. We know that 700 licences have been withheld—those are 700 doctors who would have been capable of practising on patients a year ago who cannot now—and 77,000 people have gone through a detailed process which examines their practice, looks at the views of their colleagues, looks at the views of their patients and looks at whether they are engaged in audit of their practice to ensure that it has continuous improvement; it looks at their complaints and their compliments. It is quite a detailed endeavour. I would not want it to be dismissed as box-ticking.

Dr Hulf: As Terence says, I too have gone through the revalidation process. My personal view as a doctor is that my appraisal process has changed. I have been part of an appraisal process for the last 10 or more years—more like 15. My appraisal is quite different now. I do not just provide documentary evidence; I provide reflection on that evidence and I think about it a great deal more. I no longer practise clinically so I do not have patient feedback, but I certainly have participated in colleague feedback—and, indeed, feedback in lieu of patients from the organisations and stakeholders that I work with in my current employment.

In our perceptions survey at the GMC, which we conducted towards the end of last year, more than 25%—more like 30% or 35%—of doctors said that they reflected more on their appraisal. It is not 100%, but it is a great deal improved from what it was. We do not have 100% appraisal rates, as we demonstrated in the submission that we gave you, but it is a very substantial rise from 63% to 83%. This is a quality improvement initiative, and we hope and expect that over the development of revalidation that would continue to improve.

Niall Dickson: As everybody has said, it is early days and I would not want to be complacent, but all the evidence we are getting from employers is that this thing is making a difference. They are starting to identify doctors who need help and support that they were not identifying before—doctors who have never had an appraisal, often doctors who are not specialists, not part of the specialist register and not GPs. Those are the lost tribe, as it were, who did not have appropriate support but are now getting support. Somebody is looking at their practice and they are able to reflect on the results—groups like locum doctors and others. For the first time, the system is starting to have some traction.

One chair of an NHS trust said: “For the first time we are able to see inside the medical black box. What is the quality of the doctors that we actually employ?” It can be a really significant patient safety advance. We will have to evaluate it properly. That will take some time and we have, as Terence mentioned, commissioned an independent report from

academics across the UK who will be doing this. The DH is also doing a separate study. But all the evidence we have to date from the very processed stuff is that 83% of doctors in England now are getting appraisals. There were groups of SAS doctors who were down at 20% in some institutions; about four or five years after the NHS said this was a mandatory thing, it was not being done. Revalidation has driven that up, but more importantly, doctors themselves are saying, “Yes, it has made me reflect more on my practice,” and responsible officers are saying they are able to identify problems as a result of this process.

Q69 Charlotte Leslie: As with everything, everyone has different opinions. You have spoken to some rather different doctors from the ones I spoke to, who said, “It is the kind of revalidation process that, if you wanted to tick the boxes because you wanted to get through and knew how to tick boxes, it is a process made for you, but if you are really interested in getting on with your job, it is quite burdensome.” But there is always a variety of opinion. Will the GMC publish complaints from doctors about the revalidation system?

Niall Dickson: Yes. I am not aware of complaints by doctors about revalidation, on the whole, in the profession. Of course, you are right that there are a group of doctors, and I think there will probably be a normal curve of responses—there are real enthusiasts and there are a whole lot of people in the middle—but certainly our impression and the perception survey that we have done indicate that the vast majority of the profession, first of all, accept it.

There is nobody outside our offices with placards saying, “Give me revalidation—give it to me now!” On the other hand, there is recognition within the system that it is having an effect, and actually if you talk to responsible officers you will find that near 100% of the 600 or 700 responsible officers who are doing this business and are responsible for it are not only enthusiastic—they are extremely enthusiastic and say that it has made a difference. It may not make a difference to your big high achiever, as it were, who is doing all this stuff anyway, but for most of us who are in the middle of a normal curve, if it encourages a bit of self-reflection and enables the system to start identifying people who are underperforming in the system at an earlier stage—again a comment I got today from a responsible officer: “We are able to start identifying people at an earlier stage”—then it will make a difference.

But the proof of whether your critics are right or I am right will be shown when we do the full studies of this. All we can report at the moment is that we are encouraged that the system is up and running. It is running, as far as we can do it, relatively smoothly, and we think it is starting to have traction.

Q70 Charlotte Leslie: Have you received any complaints about the process?

Niall Dickson: I am not aware of any.

Professor Stephenson: Not to my knowledge.

Q71 Charlotte Leslie: You have not received any complaints about the revalidation process from doctors.

Niall Dickson: I have had no formal complaint, as far as I am aware. I will check. I can think of one doctor—I will give you the group that this individual was attached to—who cannot find a responsible officer and a designated body. There is that kind of individual who is very difficult for us and we will, unfortunately, have to either ask them to give up their licence or require them to undergo some form of checking process to make sure that they are up to standard. Yes, of course, there is noise from that group, many of whom work overseas or who have been retired for a long time or whatever. I have received a couple of formal complaints from that category of doctor. In terms of mainstream doctors, no, they certainly have not come to me, but the organisation may have dealt with individuals.

Q72 Charlotte Leslie: If you find they have, would you be able to let the Committee know just for our interest?

Niall Dickson: Certainly.

Q73 Charlotte Leslie: The second thing is that you often hear anecdotally—I have certainly heard—that doctors, particularly good ones, are leaving the profession because of the burdensome revalidation process. Is that a picture you would recognise?

Professor Stephenson: It is not a picture I would recognise, and I work in a very large hospital with a large number of consultants. Of course all doctors complain, as I am sure all professionals and you yourselves do, about bureaucracy and administration. Nobody likes it. I do not hear people saying, “This is wonderful. I’m so delighted I’m going through revalidation,” but I have not heard a single person say they are contemplating either leaving the profession or the country because of it. Having gone through it, it is not hugely burdensome if you are doing your job as you should be.

Q74 Charlotte Leslie: You said in written evidence that the GMC’s survey of complainants involved in fitness to practise cases had highlighted areas where the GMC could do more to support those who made a complaint about a doctor. What kinds of problems have been identified by the people you surveyed?

Niall Dickson: Among complainants traditionally there is a feeling that the GMC is a very remote organisation, that it is quite legalistic in the way it handles complaints and that when we go off and start to investigate there is a period of silence when the complainant is not quite sure what we are doing. Obviously, and this is almost intractable, there will be people to whom at the end of the process we say it does not reach our threshold or there is not the evidence, and we have not been able to do it.

We talked about the pilot of meetings with doctors. One of the things we have done in the last year is to introduce a pilot, which we are now rolling out throughout the UK, on meeting complainants. Anybody who is a complainant and goes into our serious stream 1 investigation has an opportunity to meet a GMC person at the start of the complaint, when we can explain what we can and cannot do. It is also an opportunity, frankly, for us to hear

directly and in an informal way what the complaint is. The response—we have done an independent review of this—is overwhelmingly positive. These people are saying, “It is the first time anybody has spoken to me, never mind just the GMC, but the NHS or anybody, and actually listened to what I am trying to say.” That bit is hugely positive.

You are offered a meeting at the beginning and at the end of the process. At the end of the process, inevitably, some of those meetings are more difficult, because we have not taken action and the complainant may wish to, but again, overwhelmingly, the reaction of those who have gone through those meetings has been very positive. We are following up all the recommendations around that. One of them was that people wanted us to pay for a supporter to go with them to the meeting, so we have decided to do that. Anybody can bring along either a friend or an advocate, because it can obviously be intimidating having that contact. That has to be the model going forward—that you have much greater contact.

We are not a body that can provide redress for complainants and that is always going to be a tension in our processes, but we can be a body that genuinely listens to people, keeps them informed along the way, has an individual that they can relate to going through the process and which bothers to go back and explain, even if the outcome is not what they wanted, why we have done that and what stage we have reached.

Q75 Charlotte Leslie: Did your survey find any difference between the complainants within the system, say, employers and other doctors, and those outside the system, patients and others?

Niall Dickson: I think the study you are referring to is for patients and relatives, not for employers. Our relationship with employers and the way they handle complaints is something, again, we should revisit as to what is their view of us. But there is no doubt that our relationship with employers has undergone a massive change over the last few years, because we have put in place the team of employment liaison advisers.

Every responsible officer or employer in the country has a link to a GMC person who visits them, and talks them through their cases, any concerns they have about individual doctors and any issues around revalidation. Traditionally, employers would have dealt with an amorphous, huge organisation, where they did not know who they were dealing with and would have dealt with different individuals. Now there is one person who deals with each employer and will provide them with support and advice as they manage their responsibilities.

Q76 Charlotte Leslie: Finally on that, we get quite a lot of correspondence from people saying that GMC procedures are quite inflexible, so if you want to complain about the actions of, say, two or three GPs in a surgery, it ends up in three separate investigations as opposed to an holistic investigation. Do you have plans to be more flexible and have more common sense in your approach?

Niall Dickson: I might need to come back to you on the legal issue. I will check this out and give you chapter and verse, but the way we do it is because of the legal framework in which we are dealing with it. It is not a question of whether we apply common sense or not. It is because of the legal framework that we have, but if we can be more flexible—

Q77 Charlotte Leslie: Is that something you might be looking at?

Professor Stephenson: We are a regulator of individual professionals, not a system regulator. It is something that I am sure we will look at and that Robert Francis, post-Mid Staffs, asked us about. We work more closely now with the CQC, for example. But we are a regulator of professionals.

Q78 Charlotte Leslie: Finally, if the Chair will indulge me, just on the Mid Staffs and Robert Francis whistleblowing thing—I know you discussed Hooper earlier and I am sorry I was late and missed it—could you confirm whether or not people submitting evidence to the Hooper review are able to do so without having to present it to the GMC, so they can submit evidence to Hooper in confidence?

Niall Dickson: Absolutely. I am sure Sir Anthony would be absolutely willing to hear anything.

Valerie Vaz: Do you want to end now, Chair?

Chair: We are going to come back and David is going to take over in the Chair.

Q79 Valerie Vaz: Maybe you can respond at the end, but we have had written evidence from someone to say that part of the problem is the medical directors who are sitting on the whistleblowers and not providing proper evidence, or trying to make them go away, yet part of the revalidation process is that you are feeding into medical directors. How do you reconcile the two roles for the medical directors? Are the medical directors the right people for the process?

Dr Hulf: There were many years of discussion before revalidation started, as you are well aware, as to exactly how this process would run, and the decision was taken by multiple stakeholders, not just the GMC, that the responsible officer might be—might be—the medical director. The responsible officer does not have to be the medical director, and the individual designated bodies appoint their own responsible officer. That process is entirely without the GMC.

Responsible officers are, of course, bound by the responsible officer regulations, and indeed the boards of health care authorities—be they in primary or secondary care—also have statutory obligations in this process. As to whether they are the right people or not, we have a responsible officer reference group which we run twice a year, in both London and Manchester, so we have a representative group of responsible officers. As responsible officers, we all attend our regional network meetings. I would say that, among responsible officers, there is not particularly a feeling that those who are medical directors as well find a conflict in that role. The medical director, of course, knows the staff, and indeed the responsible officer needs to know the staff. They do not know them all individually, but they have responsibility within that organisation. We could not comment on whether they are the right or the wrong people. We do not have a lot of evidence that they are not the right people.

Niall Dickson: The model chosen by Parliament was an employer-driven model of revalidation. There are different models, but the evidence is that clinical governance has improved as a result of that model. *[Interruption.]*

Q80 Chair: I am really sorry; it is unusual to have so many Divisions. I am afraid that we are going to have to have another pause. After we return, David Tredinnick will be in the Chair because I have something I have to go to, but thank you. I am sorry it has been a marathon session for you, but I hope you are happy to stay on slightly longer. Thank you.

Sitting suspended for a Division in the House.

On resuming—

In the absence of the Chair, Mr David Tredinnick took the Chair.

Q81 Chair: The Chair, being engaged elsewhere, has asked me to take over, so I shall be in the Chair for the rest of this session. I would like to start by asking you some questions about language testing, which follow on from the questions I asked you earlier about understanding the growth in complaints. Before I do, I want to ask you how many of the complaints you receive come from vexatious litigants—in other words, people who have no business complaining in the first place and are just mischievous. Do you have any idea of the percentage of complaints that you would strike out before they proceeded?

Professor Stephenson: We should make a distinction. We do not think of vexatious litigants; we think of vexatious complaints. Rather than labelling the person, it will be the complaint, because of Peter crying wolf: sometimes a person who has made vexatious complaints may make a real one. The number is very small. We have a vexatious complaints policy, which was introduced when I was on council in 2008-2012. It has very rarely been invoked—once.

Q82 Chair: How would it be invoked? What would be the decision-making process? How do you assess whether a complaint is vexatious? We as politicians have complaints that fall into that category.

Niall Dickson: The answer is—this is something Sir Anthony Hooper will doubtless reflect on—that we frequently get complaints followed by counter-complaints, in other words one person following up another; or you can get a general practice where the partners have fallen out with one another and you get one complaint countering another. The difficulty for an organisation like us is that we have to look at each complaint on its merits and investigate it as if it were one. That is why the vexatious element has been rarely used. In trying to find a way through this, we certainly hope that Sir Anthony Hooper will help us in the sense of, as best we can, identifying where there are complaints that are vexatious or where there are, for example, whistleblowers who are being inappropriately referred into our systems and whether we are as good as we hope we are at identifying where there are individuals who have been wrongly pursued.

Q83 Chair: Thank you very much. Moving on to responsible officers, if a responsible officer is tasked with resolving a stream 2 complaint locally, will that mean that the GMC is no longer involved in the complaint and has no oversight of the process?

Niall Dickson: We have reformed stream 2. These are the less serious complaints, and we reckon probably for each responsible officer, even the ones who have a larger number of doctors, we are probably talking about one or two a year, so we are not talking about a huge extra burden placed on responsible officers. All that we are asking them to do is what they should be doing anyway.

In the past, when we received a low-level complaint we would have written to all the employers of that doctor and said, “We do not think this is serious enough for us to do anything with. Do you know anything about this doctor that we don’t?” When they wrote back saying, “No, we don’t know anything,” as invariably they did, we then had to write to the complainant, saying, “We are now having to shut this,” so it annoyed the complainant. It also obviously annoyed the doctor and everybody else, and did not achieve what it was meant to achieve.

Instead, under the new system, we will write to the doctor and their responsible officer and say, “This is not a matter for us, but we want you to reflect on it.” When I say “not a matter for us”, our employment liaison adviser will discuss the matter with the responsible officer, so if there is anything that needs to be followed up we will follow it up. But we think it is a much simpler and faster way of dealing with low-level complaints.

Q84 Chair: In other words, you retain oversight.

Niall Dickson: We would have that discussion. The responsible officer may well say, “I’ve dealt with this. It’s a minor matter,” or whatever, but we certainly would have a discussion with them about it.

Q85 Chair: Following on from that, what assessment have you made of the capacity of responsible officers to deal with an increasing number of stream 2 cases?

Niall Dickson: As I say, we are talking about one or two a year, and we do not think that is significant in any way in terms of people’s work load.

Q86 Chair: Although the GMC may have decided that a complaint does not warrant a stream 1 investigation, nevertheless that complainant will regard their grievance as a serious matter. What resources will responsible officers be given to deal with complainants and manage the process? Do you have a budget?

Professor Stephenson: If it goes back as a stream 2 to the responsible officer to deal with, the resources for it come from that NHS trust or that general practice. It is for them to support the complainant. They will have a formal complaints procedure. They will have a complaints liaison officer of some type. It would not be for the GMC to provide that level locally. That would be for the employer to deal with.

Q87 Chair: So they do not have additional support.

Professor Stephenson: No.

Q88 Chair: Fair enough. Last year the Committee recommended that the General Medical Council assess whether responsible officers are sufficiently close to the doctors they oversee to make sound judgments regarding language competence. Have you examined this element of their work?

Professor Stephenson: In the process of revalidation, language competence will come into it in so far as key parts of revalidation are 360-degree feedback from at least 12 colleagues, and certainly in my trust we need 360-degree feedback from at least 20 patients. If there are language difficulties or, more broadly, communication difficulties, they should be flagged up. The question of how close the responsible officers should be to the people whose revalidation they are looking at is less important than what structures they have in place.

Obviously, if it is a large trust with 500 consultants, it is accepted that the one responsible officer may not know everyone in a very personal way. Indeed, that may not be appropriate. But provided they have underneath them delegated responsibility to clinical directors or other leaders who are taking action and who do know the person's practice, that is fine. But clearly, compared with a small organisation where the responsible officer is responsible for 10 people, it is going to be quite difficult where you have 500 consultants. We accept and acknowledge that.

Q89 Chair: To get some idea of the scale of the issue, I understand from the evidence you submitted that 1,246 doctors from Europe were required to provide evidence of their English language competence. Who ultimately is responsible for deciding whether a doctor's language skills should be formally assessed before being granted a licence to practise? Where does the buck stop?

Professor Stephenson: That is a slightly separate question. Let us first of all take non-EU doctors. All non-EU doctors have to pass a language test called the IELTS—the international English language test. It is a test of written and spoken English and I think the score required now for health professionals is 7.5, or something—quite a high score. That is unequivocal. You have to sit that and furnish evidence of it to get past first base.

For EU doctors, with the free movement of labour under EU law, we are not entitled to apply a similar blanket to all EU doctors saying, "You must all have tests of English language." What we have been able to achieve—or my predecessors have with your very strong support—is that if we have prima facie evidence that we think their language is not good, from telephone conversations with them, from the quality of the written English on their application form or from the fact that they invite other people to phone on their behalf, we are allowed to request them to undergo language testing. That is the figure you cite of 1,240. Of those, over 100, because of their language, have been allowed to go on the register but not given a licence. About 220 have demonstrated proficiency in English

and have been given a licence and about 900 are continuing to progress through the system.

Q90 Chair: Is there as well what we might call a common-sense test, where someone may possess the language skills but is clearly unintelligible?

Professor Stephenson: Yes. If you are an EU doctor and you are clearly unintelligible, we would be allowed to request you to provide evidence of your English language capability.

Q91 Chair: But he might say, “I have a university qualification in English. You may not like my accent; you might be prejudiced against me because I come”— for example— “from Romania.”

Professor Stephenson: He might say all of those things but we are entitled under the law that you helped us achieve to say, “That’s fine, but we require you to demonstrate this through a formal test.”

Q92 Chair: But if it is a written test and he—

Professor Stephenson: No, it is a written and spoken test.

Q93 Chair: So he can pass on the written and fail on the spoken.

Professor Stephenson: He fails.

Q94 Chair: He would fail not just on the construction of the language but on the clarity of his speech.

Professor Stephenson: Intelligibility, yes. Absolutely.

Chair: Thank you very much.

Q95 Andrew George: I want to move to the issue of ethics, particularly that of potential conflicts of interest, and the role of the GMC in the setting of guidance, which, as I understand it, prohibits registrants from engaging in financial arrangements that could unduly influence their decisions about the best care for their patients. Is this an area where the GMC has reflected, given the complexity of the nature of the relationships, the contracts, or the agreements that doctors are often invited or able to enter into? Is this an area you have thought is worth revisiting and reviewing at all?

Professor Stephenson: Are you asking in relation to the newer commissioning arrangements or in terms of people’s relationship with a private hospital, a pharmaceutical company or—

Q96 Andrew George: You will have seen the evidence we received from, for example, Dr Simon Peck and others. That deals with the private sector and I know that my colleague Grahame Morris wants to address that, but these things have existed for some time and it is not necessarily in relation to anything new.

I will give you an example. A GP is invited to enter into an opportunity to give a particular company wishing to demonstrate the effectiveness of its remedy access to patients with a particular condition, and is paid accordingly for that access to those patients. You know that, in different forms, this happens on a quite regular basis. Do you think it is appropriate that those patients should be told that they are part of that, and, secondly, do you think that, for example, those patients should be informed that there is a financial inducement, or at least a financial reward for that doctor?

Professor Stephenson: I do.

Q97 Andrew George: You know that there is no requirement for the doctor to make transparent that reward—indeed, one might even argue that, as it is the patients who are the factor that the company are seeking, they should share in that reward, if they were aware that such a reward was in the offing. Do you not think this is a factor that requires greater levels of transparency?

Professor Stephenson: If I understand you rightly, you are describing a scenario that amounts to research.

Andrew George: Yes.

Professor Stephenson: That would require approval by a research ethics committee. My view—I have sat on a research ethics committee—would be first of all that the patient is entirely entitled to fully informed consent, and that informed consent would include any incentives for the practitioner recruiting them. Indeed, the ethics committee would want to know about those incentives and would be very concerned if they thought that someone was being directed away from what would be the best treatment for them and into some research study purely because of a financial incentive.

Q98 Andrew George: Yes. In this area—you see in Dr Simon Peck’s evidence and other evidence—there are arrangements on co-commissioning, profit-sharing and discounts on leases and all other, if you like, financial inducements that might affect the way in which a doctor might direct their patients, but it seems to me an area which is rather murky, and the GMC does not appear to have any powers. The guidance seems to be purely generalised and there does not seem to be anything terribly specific in this area.

Niall Dickson: The guidance is specific. There is guidance in “Good medical practice”. There is supplementary guidance on commercial dealings—financial and commercial arrangements—and there is guidance on conflicts of interest. There is specific guidance and also, in response to doctors phoning us up, we will give advice and support around this. I suppose, underpinning the guidance, the principle is about transparency and openness.

You referred to a few different arrangements. We do not think there are new ethical problems arising, but we do think that, for example, in primary care doctors are more often likely to find themselves in such situations. It does not mean that that is evil or wrong, but if they find themselves in a situation where, for example, they have a vested interest in some provider, or whatever, they must absolutely declare that and recuse themselves from any decision making that would benefit that particular—

Chair: I would like to move on, if I may.

Q99 Andrew George: In terms of the potential of having an enforced and publicly declarable register of financial interests, clearly that is not something you are empowered to do at the moment, but it is something, just for the record, which the GMC is keen to see enacted.

Niall Dickson: We are exploring, we will consult on and we are looking at what a register could do and what we should put on that register, and certainly one of the things that we would consider is conflicts of interest, financial and otherwise, that you might be able to put on it.

Chair: Thank you very much. I am going to move on to Grahame Morris. I am hoping that we will conclude by half-past five at the latest.

Q100 Grahame M. Morris: Thank you, Chair. I am sorry about all the interruptions. You will be aware, because I have raised this consistently at the accountability hearings, about the conflicts of interest. It is not fair to ask Professor Stephenson because it is only his second day in post, but perhaps Niall Dickson or Dr Hulf could answer. I want to put it directly to you because Niall Dickson touched on it in response to a question from my colleague. The guidance and instruction of the GMC is quite specific: paragraph 80 says—I am paraphrasing here from my notes—that doctors should not accept gifts, hospitality or inducements that would affect the way doctors prescribe or commission services for a patient. That is quite clear, isn't it?

What are you as the GMC doing in terms of your practice to identify conflicts of interest, and specifically do you employ any accredited counter-fraud specialists? While you are thinking about that, if you will indulge me, I hope you have seen the evidence that has been submitted to the Committee, and referred to by Andrew George my colleague, from Simon Peck. I was quite shocked when I read it. I was not aware—in fact Dr Peck says—that this is a widespread practice. I wanted to ask you whether that is true about these incentives and payments. I understand that you regulate doctors in the public and the private sector—in the NHS and in the private sector—so I want to come back to that, but could you answer those first questions? Mr Dickson is probably best placed.

Niall Dickson: We will investigate any instance where there is evidence that a doctor has contravened that guidance. In the more general sense, if there were an inquiry, for example, by the competition authority, or whatever, we would look at that, and indeed we are looking at the results of that inquiry at the moment.

Q101 Grahame M. Morris: You have anticipated what I was going to say, because you are aware that the CMA investigated private health care and issued an order in October last year which, in effect, banned incentive schemes for doctors. Can we reasonably assume that that suggests that such schemes were widespread and, if that is true, what are you as the GMC doing to investigate that? Are you just waiting for someone to whistleblow or do you have some forensic counter-fraud specialists?

Andrew suggested some of the schemes, and they are laid out in the written evidence: cash commissions paid by a private laboratory to a doctor based on ordering tests; use of leasehold property free or at discounted rates; other free services provided by private hospitals in return for the same commitment; shares in joint ventures with private hospitals, sometimes funded through loans; and profit-sharing schemes based on increasing the hospital's income or turnover. That is a clear conflict of interest, in my opinion. Should you not be rooting that out? In particular, the Hospital Corporation of America, who have been convicted in the United States on two counts, with substantial fines awarded against them, are now operating in the United Kingdom, so is there some basis for looking at their business practices?

Niall Dickson: Just to be clear, we are a regulator of individual doctors. There is a system regulator which is responsible for the public sector and the private sector; it is known as the Care Quality Commission. They register all those organisations. The answer is that we have no power and have never been given power to employ counter-fraud investigators or to send investigators into sites—we simply have no authority to do that—but if a complaint was made, or indeed we got evidence through CQC that such a practice was going on, we would do it.

We will, in a proactive sense, look, and we are looking, at the conclusions of the competition authority report. We will take action if we can establish evidence of individual doctors, which is what we deal with, having contravened our guidance. The examples that you have given are allegations of clear breaches of our guidance.

Q102 Grahame M. Morris: I know time is short, and I have waited patiently for my turn, but it is a really important issue. Frankly, I do not think I am satisfied with the response of the GMC, because if, as Simon Peck suggests, this is a widespread practice and if there is some kind of institutional reluctance to whistleblow, it is beholden upon you to seek that out and to make members aware that these practices are unacceptable.

Niall Dickson: We have made it absolutely clear to the profession; we have been very proactive on the conflicts of interest question and indeed have contacted every doctor, reminding them of their responsibilities in relation to conflicts of interest. We can do that proactively. What I do not think we can do is send in a team to start investigating an institution, because we do not have powers to do that. We are looking at that report and seeing what action we might be able to take in response to it.

Q103 Chair: Thank you, Grahame. I am going to bring in Barbara in a moment and then Charlotte, but running on from Grahame's question, I wondered whether you have considered inducements to doctors to use particular medications. If you go into any doctor's surgery, you often see point-of-sale material from different drug companies encouraging

them to use certain products, or incentives to go to conferences that might be in Barbados, for example, or some other quite attractive place if you are working in the deep winter here. Has any of that sort of thing come across your desk?

Professor Stephenson: As we are trying to get across, we need a complaint to trigger an investigation. We do not have the power to go in prospectively, even if it seems there is a problem in the system. We do not have those powers from this Parliament. Doctors are given Post-its and free pens.

Q104 Chair: May I stop you there? It is not just Post-its and free pens, is it? There are major incentives given to some doctors to attend conferences by certain companies which promote certain products. I worked in the advertising industry at one point; there is a very strong marketing push to encourage doctors to go down a particular path.

Professor Stephenson: There is.

Q105 Chair: I am suggesting to you that this is a danger zone and, even if you say you have to have complaints before you do anything, it is something you should be aware of and have a view on.

Professor Stephenson: We are aware, and we have very clear guidance. If someone made a complaint which suggested that a doctor's practice or prescribing was at odds with what was best for the patient and had been influenced by a conference trip to Florida, we would have to act on that and investigate it—absolutely.

Chair: Thank you very much.

Q106 Barbara Keeley: I join my colleague Grahame Morris in being concerned about this. For the record, we are not talking about Post-its and free pens. In the evidence this Committee had from Simon Peck he said that he interviewed the chief executive of the laboratory involved in the matter he reported to you, who confirmed that the payment in at least one case was sufficient to pay private school fees. I think we know that we are talking about thousands, not about Post-its, school pens or even trips to conferences. The evidence also mentions the organisation HCA being fined \$1.7 billion in the United States.

These are serious matters. In any sector—we have been through these issues in the House of Commons and they still persist—transparency and making people aware that this will not be tolerated is the most important thing, and to shine a light on it is quite important. Clearly that evidence is trying to shine a light on that, and I join my colleague in being concerned that you did not follow through with this. We were told that the GMC did not intend to investigate or take any action on the report that was made to you. It may be that following this meeting, of which we are quite near the end, you should review again the evidence that came to you and see if you can do anything.

You talked about the relationship that you are developing with doctors. The important thing there is that if it is quite clear that the case you are putting forward, or what you are recommending, is being flouted so substantially, and it looks from this evidence as if it is being flouted substantially, you should make it clear that that is intolerable. There is no point

in having under the duties of a doctor, as my colleague outlined earlier, that doctors are not to accept any inducement, gift or hospitality, and then have reports of very substantial inducements.

Chair: Okay.

Barbara Keeley: There is a final point I want to make on this, Chair, because it is important. These matters will be gaining ground as the private sector moves more into the NHS. We are talking about a situation where there were private laboratories and private hospitals, but this sector is moving into the NHS after the Health and Social Care Act and there will be many more opportunities and temptations. It may be that it would be wise for you to review your position and to make it clear that you as an organisation are serious about what you say the duties of doctors are, and that they are taken more seriously.

Niall Dickson: I absolutely take that on board, but, just to be absolutely clear, I am deliberately not commenting in detail on a report that we are currently looking at, because I do not want to prejudice anything that we might subsequently say. Do not take from what I say that we are absolutely relaxed and not doing anything. I just have to be careful about what I say in our response to looking at that report. On the wider issue, we have drawn attention to doctors and we can do so again—

Q107 Barbara Keeley: I think you need to.

Niall Dickson: But the fact is that these doctors, if they are doing this, are absolutely clear that what they are doing is wrong. It is not that doctors are wandering around thinking, “Yes, I can do this. I can influence my prescribing habit because that’s all right and the GMC doesn’t care about it.” They know perfectly well that they are doing wrong if these allegations are true. They know these incentive payments are—

Chair: That is very helpful, thank you.

Q108 Charlotte Leslie: I have a couple of things, one specific and one general which I have been asked to run past you. Please forgive me if you have talked about this and move me on if you have, but earlier in the year, as you will remember, there was a story and a concern about the GMC’s use of un-uniformed guards and surveillance in a case, which was known to the defendant. The doctor and his lawyers knew these un-uniformed guards were there, but the complainant did not; she was told that they were guards on work experience. I understand you said you had learned lessons from that and followed up with the person involved. What are the lessons you have learned and what action have you subsequently taken to stop what I think most people would say was not appropriate practice, and even wrong practice?

Niall Dickson: I will start and maybe David will finish. We have cases where we have to bring in somebody who just keeps an eye on things. We have had counsel for the GMC—a woman—punched in the face by a doctor; we had another occasion where somebody was picked up. These can be quite tense situations and we have to sometimes bring people in. The advice given to those security people was completely wrong and should not have been

given. We have been absolutely up front about that. The advice was, “If you are asked, say you are here on—”

Q109 Charlotte Leslie: Do you know who gave that advice and what measures have subsequently been taken? Has it been internal?

Niall Dickson: It has been dealt with internally, yes. It was well meaning but quite wrong. We still need to have them from time to time, but, as I think David will explain, people who are at MPTS hearings now wear a badge that says “Steward” on it; it is absolutely clear what their role is. We have sorted it out and learned the lesson.

His Honour David Pearl: I have nothing really to add. We learned from that particular incident and it will not happen again.

Chair: That is a good note for us to end on. May I, on behalf of the Commons Health Committee, thank you all very much for coming? It has been a very helpful session.