House of Commons
Health Committee

2013 accountability hearing with the General Medical Council

Tenth Report of Session 2013–14

Report, together with formal minutes relating to the report

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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Summary

The GMC is the independent regulator of doctors in the UK, the Channel Islands and the Isle of Man. On 10 December 2013 the Committee took evidence from the GMC. This was the third accountability hearing in a series which the Committee proposed should be an annual feature of its work throughout the course of this Parliament.

Managing professional concerns

The GMC now receives more complaints than ever before. The GMC explained that the rise in complaints is broadly in line with the experience of other health care professions in the UK and also internationally. The Committee concluded that the GMC must now seek to better understand what has driven these complaints and the detail behind them. The GMC should also examine whether high rates of referrals from a particular organisation indicates a willingness to refer concerns to the appropriate national regulator or an inability of local systems to act on professional concerns. The GMC should also play a leading role in helping the Government and NHS England to understand the relationship between patient complaints, the ability of registrants to raise concerns and a provider’s workplace culture.

The Committee concluded that the GMC’s national training survey and confidential helpline both represent useful mechanisms for registrants to report professional concerns, but they will not in themselves perpetuate a change in professional culture. The GMC should concentrate its efforts on ensuring that a doctor’s working environment permits the raising and discussion of concerns within the workplace. As part of this the GMC should reiterate to all of its registrants that they have a professional obligation not only to report concerns when they arise, but also to act to address problems if concerns are reported to them.

Revalidation

In December 2012 the GMC introduced revalidation for all licensed doctors. The GMC said that the data does not yet exist to confirm that revalidation has identified more failings in practice than old appraisal processes, however they believe that revalidation had changed the way in which health providers manage their clinical staff.

The Committee concluded that at its next accountability hearing the GMC should present a formal assessment of the evidence relating to revalidation to ensure that it is making a significant contribution to the improved practice of doctors.

The Committee found that the tone and emphasis around responsible officers has altered as revalidation has been launched. The Committee is concerned about this development and recommends that the GMC should clarify precisely the nature of the personal
responsibility of the responsible officer.

Information published by the Government shows that with one responsible officer located in each NHS England local area team there are 27 responsible officers for approximately 45,000 GPs in England. The Committee believes that the ability of each responsible officer to form the necessary professional relationship with the doctors they oversee will, in part, be determined by the total number of doctors they are required to support. The Committee is concerned that changes to the management structure of the NHS must not be allowed to undermine the effectiveness of professional regulation.

The Committee’s report of the 2012 accountability hearing with the GMC found that 42% of doctors were not affiliated with designated bodies which had introduced a policy for reskilling and remediation. At the Committee’s 2013 hearing the GMC revealed that the launch of revalidation has prompted a sharp rise in the number of organisations publishing formal remediation policies. Approximately 85% of organisations now have a formal policy in place. It is concerning that 15% of employers have still not complied with the principles of good practice.

The successful incorporation of patient feedback into the process of revalidation depends on more than just the regularity by which feedback is required. The quality and applicability of feedback is crucial as the information has to be useable in a way in which it can inform and improve a doctor’s practice. At our next accountability hearing with the GMC the Committee shall seek specific evidence about the regularity and effectiveness with which patient feedback is incorporated into the revalidation process.

**Fitness to practise**

The Committee is satisfied with the overall conclusion of the Professional Standards Authority’s audit of fitness to practise cases that the GMC’s processes protect the public. The Committee believes, however, that failures to provide complainants with clear or adequate reasons for closing investigations must be addressed as a priority if the GMC’s fitness to practise processes are to be regarded as fair and transparent.

Clarifying the procedures for allocating investigations between stream 1 and stream 2 would also help to instil greater public confidence in the GMCs fitness to practise processes. The GMC should ensure that in future audits no cases are be called in to question because their triaging meant key information was not gathered.

The Committee believes that the GMC’s pilot scheme to sanction registrants without recourse to full fitness to practise hearings can only be regarded as successful if the registrant can demonstrate that they have genuinely learnt from the experience and changed their practice as a result of the sanction. The Committee remains concerned that registrants may accept sanctions to avoid full fitness to practise hearings without demonstrating that they fully understand and accept their own failings. In their analysis of the pilot scheme, the GMC must examine whether those doctors subject to sanctions have
demonstrated an understanding of their own failings and changed their professional practices as a consequence. To prevent the scheme being regarded as a soft option for registrants we believe that the GMC’s powers should be extended to allow the application of tougher sanctions.

The Committee concluded that it was an error on the part of the Government not to introduce a section 60 order in 2014 to allow the GMC to appeal Medical Practitioner Tribunal Service decisions. The likelihood of inclusion of these provisions in a draft bill in the next parliamentary session will result in further delay. A section 60 order should be introduced by the Government at the earliest opportunity to allow for implementation of this reform as soon as possible. The necessity of this is only underlined by the fact that in a few historic cases, fitness to practice tribunals failed to remove from the register doctors convicted of serious sexual and violent criminal offences.

**Language testing**

The Committee welcomes the fact that the Government is legislating to allow the language testing of registrants from the European Economic Area in cases where a doctor’s communications skills are of concern. We note that responsible officers will be tasked with identifying concerns and undertaking testing. In their assessment of the performance of responsible officers the GMC should evaluate whether they are sufficiently close to their registered doctors to make informed decisions concerning their ability to communicate with patients.

**Doctors participation in medical research**

There is a compelling case for the GMC to hold a public register of doctors’ interests with the responsibility for maintaining the accuracy of the register sitting with registrants. Although the Committee welcomes the fact that the GMC is willing to explore this, we believe that the regulator should examine the practical considerations of developing a register which is reliable and open to public scrutiny.

The Committee welcomes the GMC’s recognition that the contemporary research landscape no longer offers any valid justification for failing to publish the results of negative drug trials. It is now essential that the GMC re-words its guidance so that the need for transparency is made explicitly clear. The GMC should make all registrants aware that failure by a doctor to ensure publication of the results of medical trials constitutes a serious breach of professional obligation.
1 Introduction

Background

1. We report below on the accountability hearing the Committee held with representatives of the General Medical Council (GMC) and the Medical Practitioner Tribunal Service (MPTS) in December 2013. This is the third hearing in a series which the Committee proposed should be an annual feature of its work throughout the course of this Parliament.

2. On 10 December 2013 we took evidence from GMC witnesses Professor Sir Peter Rubin, Chair of Council, Niall Dickson, Chief Executive, Una Lane, Director, Registration and Revalidation and His Honour Judge David Pearl, Chair of the Medical Practitioner Tribunal Service.

3. The GMC is the independent regulator of doctors in the UK, the Channel Islands and the Isle of Man. The main purpose of the GMC is to:

   […] protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.2

4. It aims to achieve this by controlling entry to the medical profession, setting standards for education and training, removing those persons who are deemed unfit to practise from the profession and setting the standards and values that underpin good medical practice. The four functions set out in the 1983 Act are:

   - keeping an up-to-date registers of qualified doctors;
   - fostering good medical practice;
   - promoting high standards of medical education and training; and
   - dealing firmly and fairly with doctors whose fitness to practise is in doubt.

5. In 2012 Professor Sir Peter Rubin told the committee that the GMC was planning to reform its governing council by reducing the number of members from 24 to 12 with an even division of professional and lay members.3 The council was reconstituted on 1 January 2013 with the members appointed by the Privy Council.4

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2 General Medical Council, Annual Report 2012, (July 2013), p2
3 Health Committee, 2012 accountability hearing with the General Medical Council, HC 566, Ev4, Q10
4 GMC, Annual report, p32
**GMC corporate strategy**

6. The GMC is in the final year of a three year corporate strategy which contains four themes which relate to their objectives in delivering their statutory functions. They are:

a) “Theme: Protecting the public

i) Strategic aim 1: To continue to register only those doctors that are properly qualified and fit to practise and to increase the utility of the medical register.

ii) Strategic aim 2: To give all our key interest groups confidence that doctors are fit to practise.

b) “Theme: Helping doctors

i) Strategic aim 3: To provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career.

ii) Strategic aim 4: To provide doctors with relevant up-to-date guidance on professional standards and ethics.

c) “Theme: Working with partners

i) Strategic aim 5: To develop more effective relationships with delivery partners in order to achieve an integrated approach to medical regulation in the UK.

ii) Strategic aim 6: To help shape the local, UK, European and international regulatory environment through effective engagement with decision makers, other regulators and key interest groups.

d) “Theme: Delivering value for money

i) Strategic aim 7: To continue to use our resources efficiently and effectively.

ii) Strategic aim 8: To deliver evidence based policies that demonstrate ‘better regulation’ principles, and promote and support equality and diversity.”

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5 GMC, Annual Report 2012, p3
2 Managing professional concerns

Complaints made to the GMC

7. The GMC’s written evidence provided an overview of the steps taken to support an open learning and reporting culture in the provision of health care. It also detailed the support offered to registrants who wish to raise concerns regarding patient safety. The GMC’s evidence said:

Since our last appearance before the Committee we have launched two new services to help doctors recognise and fulfil their obligations in this area:

- In December 2012 we launched a confidential helpline for doctors who wish to seek advice or raise concerns when they feel unable to do this locally. After initial assessment, these calls may either be investigated by the GMC or referred to other organisations, such as the CQC. In less than a year we have received in excess of 850 calls leading to 64 investigations into allegations which suggest that a doctor may not be fit to practise.

- We have also launched an online tool which provides practical help for doctors in deciding how and where they should report concerns about patient safety.

In addition to these new services, we continue to use our annual National Training Survey to ask all 50,000 doctors in training to inform us of any concerns they may have about patient safety in their training environment. This year, more than one in twenty doctors in training responded with a patient safety concern. Every one of those concerns has been reviewed and shared with deaneries and local education training boards so they can be investigated. They then report back to us, in deans’ reports, to state whether they were able to verify the concern and to share their action plans. We monitor the local action and improvement being taken for any new and confirmed issues.6

8. The GMC now receives more complaints than ever before and reported in their written evidence that they received 8,109 complaints in 2012. This represented an increase of 24% on 2011 and 104% since 2007.7 Most strikingly of all, the GMC said that “although complaints in general are going up, the potentially more serious complaints are those from doctors about other doctors.”8 Professor Sir Peter Rubin told the Committee that the GMC was fielding more complaints from medical directors which is consistent with the
suggestion that doctors are more inclined to report concerns to the GMC. The GMC’s Chief Executive, Niall Dickson, explained that the rise in complaints made to the GMC is broadly in line with the experience of other health care professions in the UK and also internationally and he did not believe “anything strange is happening in the UK.”

9. The GMC did not offer a definitive overview of what has driven the increase in complaints, but provided a commentary on some of the main factors. Mr Dickson told the Committee that:

   The obvious point is that patients are less deferential; they are more questioning of professionals, not accepting necessarily what they say; they have more access to information than they ever had.

   The technology itself is quite interesting and is not something we had really thought about. [...] The speed with which you are able to do that and how easy you find it to complain is a factor. In the past, you would have had to write a letter to the GMC and put it in an envelope; now you can go online and quite easily fill in a form. [...] There is something about ease of access to raising complaints as well, but we may find other reasons that I have not mentioned.

Although the reasons noted by Niall Dickson are significant they do not directly address the question of why, in the present day, registrants are more inclined to report their professional concerns to the GMC than they would have been in the recent past. Niall Dickson, however, did discuss the attempts made by the GMC to understand what varying rates of referrals from health providers may indicate, he said:

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

10. The GMC now fields significantly more complaints regarding the practice of registrants than it did even five years ago. The Committee accepts that this trend is not exclusive to doctors, or even the medical profession as a whole, but we believe the GMC must now seek to better understand what has driven these complaints and the detail
behind them. In advance of the Committee’s next accountability hearing with the GMC the GMC should report on:

- The profile of complainants and those who have had complaints made against them;
- Trends in the triggers or stimuli which prompt registrants to report concerns regarding other doctors;
- The impact of revalidation and the degree to which this has prompted medical directors to refer doctors to the GMC;
- The extent to which complaints are vexatious or made in response to an earlier complaint;
- The relationship between complaints made to the GMC by registrants and the ability of registrants to raise concerns with their own employers.

11. In oral evidence the GMC discussed the relationship that exists between referrals made to them by registrants, the willingness of doctors to flag their concerns locally and the ability of employers to manage those concerns.13 The Committee believes that the GMC should examine carefully whether high rates of referrals from a particular organisation indicate a willingness to refer concerns to the appropriate national regulator or an inability of local systems to act on professional concerns. In the long-term, the GMC should play a leading role in helping the Government and NHS England to understand the relationship between patient complaints, the ability of registrants to raise concerns and a provider’s workplace culture.

**National Training Survey**

12. The results of the GMC’s most recent national training survey are similar to the outcomes of the same survey they reported last year. At the 2012 accountability hearing the GMC told the Committee that they:

> intervened in a number of locations around the UK in the last year where we found that the standards of education and training had fallen below what we expect. This was not the only year we have done this. We do it year on year, but again we have been quite interventionist in a number of locations.14

13. The Professional Standards Authority’s (PSA) performance review noted that the GMC has a team dedicated to exploring concerns in education and training providers. They said in their review that:

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13 Q8, Q25
14 HC 566, Ev1, Q 2
The team focuses on specialties where concerns are most likely to arise (emergency medicine, obstetrics and gynaecology and surgery). This year, the team has been deployed on 10 visits and feedback from deaneries has been that the specialist GMC perspective adds weight to local processes. The team’s work also enables the GMC to be involved with designing solutions and monitoring and the GMC said that it enables better and timelier assurance that serious issues are being addressed appropriately.¹⁵

¹⁴. In oral evidence Professor Sir Peter Rubin outlined the value of the national training survey, he said the survey covers 50,000 trainees, has approximately a 95% response rate and includes “a lot of granularity in the questions.”¹⁶ In addition, Niall Dickson observed that the survey is a useful mechanism for doctors in training to highlight their professional concerns, he said:

The fact that 5% of doctors are using the survey to raise their concerns and a significant number had not raised that concern locally indicates that there is still a challenge. If you talk, as we do, to groups of doctors in training, they will tell you that if you go into a team—I am not talking necessarily about anything major—the key point is that you should feel able to point out even the minor within that team. There is still a challenge culturally within medicine and other professions about feeling able, no matter where you are in the hierarchy, to raise that matter.¹⁷

Niall Dickson also noted that the training survey represents more than just an opportunity for trainees to comment on problems or difficulties they have encountered. Mr Dickson said that because the GMC is the UK wide system regulator for training, the findings of the surveys are fed back to local organisations and deaneries are required to respond to its findings and outline how they will address the problems the survey identified.¹⁸

¹⁵. The GMC observed in evidence that they should participate in encouraging a change of culture so that doctors, wherever they rank in a local hierarchy, can raise concerns with confidence. Niall Dickson told the Committee that this can be achieved by working “alongside hospitals, employers and medical organisations.”¹⁹

¹⁶. The Committee believes that the GMC’s national training survey and confidential helpline both represent useful mechanisms for registrants to report professional concerns, but these resources will not in themselves bring about a change in professional culture. It is equally important that the GMC concentrates its efforts on ensuring that a doctor’s professional environment permits the raising and discussion of

¹⁵ Professional Standards Authority for Health and Social Care, Performance Review Report 2012-13, June 2013, para 12.20
¹⁶ Q48
¹⁷ Q9
¹⁸ Q30
¹⁹ Q2
concerns within the workplace. As part of this, the GMC should reiterate to all of its registrants that they not only have a professional obligation to report concerns when they arise, but also to act to address problems if concerns are reported to them and that failure to do so raises issues of professional discipline.

17. The GMC observed in oral evidence that its responsibilities in relation to training means that it is more than just a professional regulator and it also has a responsibility as a system regulator to oversee elements of the system which operate across the UK. It must now begin to consider how it can formally contribute the knowledge and data gained from this role to the wider management and regulation of UK health services.
3 Revalidation

Identifying failings in practice

18. In December 2012 the GMC introduced revalidation for all licensed doctors. Revalidation “is the process by which licensed doctors have to show regularly that they are meeting our standards, including keeping their skills and knowledge up to date.”\textsuperscript{20} The GMC said in its annual report that this “marked the biggest change in how doctors are regulated for more than 150 years.”\textsuperscript{21}

19. In their written evidence the GMC offered an overview of the current status of revalidation. They said that:

- We are on track to revalidate the vast majority of licensed doctors in the UK for the first time by March 2016.
- 86\% of doctors in the UK are now linked to organisations that can support them with revalidation. And we have established a route to revalidation for doctors without a designated body.
- 2,300 doctors who have not yet responded to our requests to provide information for their revalidation have received final notice letters advising them that if they fail to respond we will have to take steps to remove their licence to practise. Of these, 1,260 are registered as having an overseas address.\textsuperscript{22}

The GMC added that they “launched a major project to monitor the implementation of revalidation to assess and evaluate its impact on employers, doctors and patients.”\textsuperscript{23} This work is being undertaken by the University of Plymouth and will “take into account the perspectives of doctors, employers and patients’ groups.”\textsuperscript{24} In their annual performance review of the professional regulators the Profession Standards Authority said that by the end of 2015 “the GMC aims to have the first revalidation recommendation submitted to the GMC by the responsible officer for the majority of doctors.”\textsuperscript{25}

20. Discussing the impact of the introduction of revalidation, Professor Sir Peter Rubin told the Committee that the data does not yet exist to confirm that revalidation has identified more failings in practice than old appraisal processes. Sir Peter added, however, that in his personal opinion:

\textsuperscript{20} GMC, Annual Report 2012, p 10
\textsuperscript{21} Ibid
\textsuperscript{22} GMC (GMC 02) paras 6–8
\textsuperscript{23} Ibid
\textsuperscript{24} Ibid
\textsuperscript{25} PSA, Performance Review, para 12.16
revalidation had a major impact before it even started, because effective systems of appraisal and so on were introduced in hospitals and identified people who needed to be referred. I think the impact antedated the introduction of revalidation by maybe three or four years.26

21. Una Lane, the GMC’s Director of Registration and Revalidation, explained further that the introduction of revalidation had changed the way in which health providers manage their clinical staff. Ms Lane said:

We see many more doctors who are subject to appraisal than was the case a number of years ago. We see many more organisations that now have policies in place to identify poor performance at an earlier point in the process, and indeed have processes in place to help the reskilling, rehabilitation and remediation of doctors locally. There is some evidence thus far that revalidation, in both its planning and introduction, is making a change, but by this time next year, when we come back before the Committee, hopefully we will have more robust, hard evidence about what is happening on the ground.27

22. Revalidation has only been in operation for a little over 12 months and as yet the data does not exist to explain whether it is a fundamentally better process to identify and address failings in professional practice than the previous system which relied solely on employer led appraisals. From the perspective of employers, this process should be about more than simply helping their staff navigate revalidation and should embrace ongoing appraisal and the management of poor performance. Una Lane’s comments in this regard are encouraging, but at our next accountability hearing the Committee would like to see a formal assessment of the evidence relating to revalidation to ensure that it is making a significant contribution to the improved practice of doctors.

**Responsible Officers**

**The role of Responsible Officers**

23. Responsible Officers oversee the process of revalidation at a local level and are based in designated organisations which are typically local trusts or commissioning organisations. The Department of Health has said that the responsible officer within each designated organisation will:

- ensure that those doctors who provide care continue to be safe;
- ensure doctors are properly supported and managed in sustaining and, where necessary, raising their professional standards;

26 Q32 (Sir Peter Rubin)
27 Q32 (Una Lane)
• for the very small minority of doctors who fall short of the high professional standards expected, ensure that there are fair and effective local systems to identify them and ensure appropriate remedial, performance or regulatory action to safeguard patients; and

• increase public and professional confidence in the regulation of doctors.  

24. At the Committee’s 2012 hearing with the GMC, Una Lane said that it was not proposed that the responsible officers who oversee the revalidation of GPs should be based in Clinical Commissioning Groups (CCG) and, instead, they would sit in NHS England’s local area teams.  

Revalidation was launched on this basis, and whilst most doctors are attached to a responsible officer within their employer organisation, GP’s responsible officers are based in one of the 27 NHS England local area teams. The area teams grew out of the PCT clusters which formed prior to abolition on 1 April 2013 after the Government had proposed that all responsible officers should be aligned to a fixed geographic area.  

25. Discussing the purpose and accountability of responsible officers in 2012, Niall Dickson said "We want somebody that we can nail, quite frankly. We want somebody who is going to be on our register that we can hold accountable for doing it right." This indicated that the GMC regarded the role of the responsible officer as being that of an individual who could be held to account if the practice of a revalidated registrant was subsequently found to be wanting. The tone of the discussion around responsible officers, however, changed notably at our 2013 accountability hearing. Una Lane said that:

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

Ms Lane concluded that the “way I tend to look at the role of the responsible officer is that it is a function rather than an individual.”

26. The Committee notes that the tone and emphasis around responsible officers has altered as revalidation has been launched. The implication of the GMC’s most recent
remarks appears to be that responsible officers may not be held to account for a doctor’s performance on an individual basis in the same way as was originally envisaged. The Committee is concerned about this development and recommends that the GMC should clarify precisely the nature of the personal responsibility of the responsible officer.

**Number of Responsible Officers**

27. The Government’s proposals for responsible officers stated that it would be for NHS England to determine the number of responsible officers necessary to allow it to “adapt to changing circumstances and to determine the most effective and efficient way of providing this important function.” In its performance review the PSA commented that work needs to be undertaken to “develop sustainable, stable networks of responsible officer following the recent restructuring of the NHS in England.”

28. The Government’s impact assessment published in March 2012 noted that in the old NHS architecture each PCT nominated a responsible officer, but once PCTs began to cluster the number of responsible officers fell as constituent PCTs within a cluster nominated the same person (usually the medical director) as the responsible officer. The GMC made the same observation during last year’s hearing and Niall Dickson told the committee that “in relation to general practice, we would want the responsible officer and his or her team to know who the doctors are”. As of 31 October 2013, the GMC listed one responsible officer for each of the 27 NHS England Local area teams. In May 2013 NHS England published information which said that there would be 27 responsible officers for circa 45,000 GPs.

29. Explaining the principal that analysis of responsible officers should be about the overall function as opposed to each individual, Una Lane argued that extrapolating basic ratios of responsible officers to registrants would not help to understand the effectiveness of each responsible officer. Ms Lane said:

> It is not simply a numbers game; it is much more about whether the area teams provide the right and relevant resources to support responsible officers in delivering the statutory duties that fall on these organisations. [...] it is

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34 Department of Health, Responsible officers in the new health architecture, para 2.13
35 HC 566, Ev 10, Q 49
36 Department of Health, Responsible Officers in the new health architecture, March 2012, para 41
37 Ibid, Q35
38 Ibid, Q34
about resources provided to the individual rather than necessarily simply about the numbers.  

30. Ms Lane conceded, however, that the reorganisation of the NHS as a result of the reforms implemented by the Health and Social Care Act 2012 may have had an impact on the capacity of responsible officers to provide oversight. Asked about feedback from registrants Ms Lane told the Committee that:

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

31. The GMC’s commentary in relation to responsible officers suggests that whilst the responsible officer may embody the statutory obligations of an organisation, it is the organisation as a whole that must make sure that the resources are in place to meet its obligations in relation to revalidation. Therefore, any analysis of the success of responsible officers in overseeing revalidation must go beyond a basic assessment of the ratio of responsible officers to doctors and examine the overall resources deployed by the designated body. Nevertheless, the ability of each responsible officer to form the necessary professional relationship with the doctors they oversee will, in part, be determined by the total number of doctors they are required to support. The Committee is concerned that changes to the management structure of the NHS must not be allowed to undermine the effectiveness of professional regulation.  

32. As part of their analysis of revalidation, the GMC should review the way in which responsible officers relate to individual doctors in order to ensure that responsible officers are able to discharge their responsibilities effectively on behalf of patients. This analysis should help to determine whether the number of responsible officers available is sufficient to properly oversee the work of doctors.  

Remediation  

33. One of the concerns expressed in the Committee’s report of the 2012 accountability hearing with the GMC related to the remediation of doctors. In 2012 the Committee reported that:

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41 Q35  
42 Q36
We were concerned to learn from the Department that only 58% of doctors were affiliated with designated bodies which had introduced a policy for reskilling, rehabilitation and remediation, meaning that almost half of the GMC’s registrants are practising in bodies where there is no such explicit policy in place.

Professor Sir Peter Rubin suggested that the lack of a defined policy in so many designated bodies was not necessarily a cause for concern for doctors who took their professional responsibilities seriously:

[ . . . ] as a doctor, I and all doctors have a responsibility to keep ourselves up to date and fit to practise and not to get into that position [of requiring remediation of practice] in the first place. It is very important, as a doctor, that I say that.

Where, for whatever reason, a doctor is found to need remediation, there have always been, over all my years in practice in the NHS, ways of achieving that. There is a difference [ . . . ] between organisations that have a written policy and those that do not yet have one. But we have no reason to think that revalidation should be further delayed while waiting for organisations to have their written policy. We need to get moving and others can then be encouraged to catch up.43

34. In oral evidence in 2012 Professor Sir Peter Rubin did not express particular concern that 42% of doctors were affiliated with designated bodies which had no formal policy for reskilling, rehabilitation and remediation. He said:

Remediation has been a feature of the NHS for all the years that I have been in practice. It is not new. What is new is that one of the successes of revalidation before it even begins is that it has stimulated organisations that do not have effective evaluation and appraisal systems to develop them. That will inevitably start to uncover doctors who are not practising to the high standards that we would all wish to see. So it is bringing a sharp focus on remediation, but it would be wrong to regard remediation or revalidation as inextricably linked because they are not. Remediation is a long-term issue that has been around for a long time. You are quite right that not all organisations have a policy, but I would be astonished if all organisations had not at some stage had to remediate doctors.

[ . . . ] From all my years of practice I would be astonished if these organisations did not have—informal arrangements for remediation. They might not have a written policy, but they would have an informal one.44

35. The Committee’s 2012 report eventually concluded that:

43 HC 566 para 39–40
44 HC 566, para 43
Although we recognise the danger of focussing on form rather than substance, we believe that it is an essential element of good practice for all organisations which employ doctors to have clear and effective procedures for reskilling, rehabilitation and remediation of medical staff when that is necessary. We expect the GMC to ensure that this condition is satisfied as part of its continuing programme for the development of revalidation and we shall seek assurances about the progress made in this area at our accountability session with the GMC next year.45

In response to the Committee, the GMC said that providing resources for remediation is the responsibility of the four UK health departments. They added that the introduction of revalidation has resulted in more providers developing formal remediation policies.46

36. At the Committee’s 2013 accountability hearing the GMC revealed that the launch of revalidation has prompted a sharp rise in the number of organisations publishing formal remediation policies. Una Lane said that:

The most recent survey completed in England indicates that in the region of 85% of these organisations now have those formal procedures and policies in place. Again, we think that the introduction of revalidation has acted as something of a catalyst and driver to ensure that organisations are doing effectively what they should have been doing in any event.47

Ms Lane also observed that the presence of responsible officers may have contributed to the increase in formal policies:

From where we are sitting, the introduction of the role of the responsible officer has made a significant difference in addressing issues that should probably have been addressed before now.48

37. The Committee is pleased that significant progress has been made in ensuring that employers develop formal plans to improve the skills of the medical staff and address flaws in their practice. We believe that the GMC should continue to monitor the commitment of employers to effective remediation as well as examining why approximately 15% of employers have still not complied with the principles of good practice. The Committee is concerned that 15% of employers have not complied with this basic element of good practice.

46 Health Committee, 2012 accountability hearing with the General Medical Council: General Medical Council Response to the Committee’s Fourth Report of Session 2012–13, HC 1110, p 6
47 Q38
48 Q38
Employer Liaison Advisers

38. As part of their response to the concerns expressed about remediation in the Committee’s last report the GMC emphasised the importance of Employer Liaison Advisers who support responsible officers. Employer Liaison Advisers are based in the Employment Liaison Service and are employees of the GMC. In oral evidence to the Committee in 2012, Una Lane said that whilst low-level concerns should be dealt with locally by responsible officers the GMC now has:

in place a group of employer liaison advisers—16 in total—right across the UK. The purpose of this role is to support responsible officers in dealing with emerging concerns about doctors and in providing advice on when the GMC absolutely needs to engage where the concerns are significant and there is a role for the GMC in terms of taking action on the doctor’s registration.49

In oral evidence at our 2013 accountability hearing Niall Dickson explained that “Their job is to advise responsible officers on their—the responsible officers’—statutory responsibility”50. Mr Dickson cautioned, however, that “There is no accountability line between a responsible officer and employment liaison adviser”.51

39. The PSA’s performance review of the GMC noted that the purpose of the Employment Liaison Advisers is to build better relationships at local level with employers who are also the designated bodies in which responsible officers are based. The PSA said that that the presence of Employment Liaison Advisers will:

maintain confidence in the GMC’s system of regulation by making it easier to share information between the GMC and employers about the (continuing) fitness to practise of doctors.52

In their annual performance review the PSA commented in more detail on the work of the Employment Liaison Advisers and said:

It was anticipated that one of the benefits of the ELS (Employment Liaison Service) would be to increase understanding among medical directors about when to make a referral. While it is difficult to gauge precise figures, the GMC notes that between April and December 2012 there were 138 employer referrals where there had been explicit intervention by an Employment Liaison Adviser.53

40. In oral evidence the GMC made it clear that Employer Liaison Advisers are not part of the formal accountability structure for responsible officers. However, the Committee

49 HC 566, Ev 7, Q 36
50 Q39
51 Q39
52 PSA, Performance Review, para 12.18
53 Ibid, para 12.32
notes the significance the Professional Standards Authority has attached to the role of Employer Liaison Advisers in prompting medical directors to refer doctors about whom they have concerns.

**Incorporating patient feedback**

41. In its report of the 2012 accountability hearing the Committee expressed concern that within the revalidation process doctors were expected to seek patient feedback only once every five years. The committee concluded that:

> We consider that the requirement to seek feedback from patients at least once every five years does not sufficiently reflect the aspiration of the GMC, which we share, to ensure that every doctor seeks periodic feedback from patients. The GMC should consider setting a more challenging target which will provide greater assurance to patients that their views are regularly sought and reflected upon by their doctors.\(^{54}\)

In their formal response to the committee the GMC said:

> The introduction of revalidation means that, for the first time, all licensed doctors must seek feedback from patients. We regard this as a significant first step. In designing the process, we have sought to balance the aspirations of patients and others with the concerns from doctors and employers about the cost in time and resources of conducting formal objective reviews. However, we do recognise the need to keep this aspect of revalidation under review. This will form part of the evaluation and we will examine not only the frequency, but also the methods of obtaining feedback.\(^{55}\)

The GMC’s written evidence submitted in advance of the 2013 accountability hearing provided further commentary and stated that:

> Patient feedback is one of six types of supporting information that a doctor must collect for revalidation at least once in every revalidation cycle, usually every five years. Doctors need to review this feedback with their appraiser, reflect and act on what it says about their practice and performance. [...]\(^{54}\)

> [...] we are conscious however that more can be done to ensure patient views are regularly sought and reflected upon and we will keep this aspect of revalidation under review. As part of our evaluation of revalidation we will examine the frequency and the methods doctors use to obtain patient feedback. We will also continue to work with patient organisations to raise

\(^{54}\) HC 566, para 67

\(^{55}\) HC 1110, p 5
awareness of revalidation and the role patients can play in providing feedback.\footnote{GMC (GMC 02) para 14}

42. The regularity at which patient feedback should be sought is not the only consideration in assessing how feedback should be incorporated into revalidation. Una Lane told the Committee that providers have become much better at seeking structured feedback from patients, but she added:

Our view is that it is not simply a matter of moving from once every five years to twice every five years, and that will be fine and everybody will be happy. We need to get much more sophisticated about how we engage with patients on this particular issue.\footnote{Q41}

43. The Committee agrees with the GMC that the successful incorporation of patient feedback into the process of revalidation depends on more than just the regularity by which feedback is required. The quality and applicability of feedback is crucial as the information has to be able to inform and improve a doctor’s practice. The challenge for the GMC is to begin to develop more sophisticated mechanisms for incorporating the views of patients into revalidation. At our next accountability hearing with the GMC we shall seek specific evidence about the regularity and effectiveness with which patient feedback is incorporated into the revalidation process.
4 Fitness to practise

Professional Standards Authority assessment

45. The PSA’s review of the GMC’s overall regulatory performance endorsed the GMC’s fitness to practise procedures. It said that:

The GMC continues to meet the Standards of Good Regulation for fitness to practise. It has maintained an effective, transparent, proportionate and secure fitness to practise process and has achieved this against a backdrop of rising fitness to practise case volumes.58

46. The PSA provided an overview of their review of final fitness to practise decisions. They reported that they “did not appeal any GMC cases in 2009, 2010, 2011.”59 The status in 2012 and 2013 was:

<table>
<thead>
<tr>
<th>Total cases reviewed</th>
<th>Total GMC cases reviewed</th>
<th>Total appeals</th>
<th>GMC Appeals</th>
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<tbody>
<tr>
<td>2012</td>
<td>2559</td>
<td>397</td>
<td>5</td>
</tr>
<tr>
<td>2013</td>
<td>2099</td>
<td>219</td>
<td>7</td>
</tr>
</tbody>
</table>

They added:

We do not attempt to draw conclusions about the reasons behind the rise in the number of cases that meet the threshold for appeal. The numbers are too small to allow us to do this. However, we will continue to monitor the situation.60

47. The Committee’s report of the 2012 accountability hearing concluded that the GMC’s 15 month target to conclude 90% of cases was “insufficiently challenging” and the GMC should report on the number of cases concluded within 12 months.61 In their written evidence sent to the Committee in advance of the 2013 hearing, the GMC said they have reviewed their Key Performance Indicators and replaced the 15 month objective with a target of 12 months. They noted that they met this target in September and October 2013. In addition the GMC’s evidence said:

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58 PSA, Performance Review, para 12.26
59 PSA (GMC 03) para 4.1
60 Ibid para 4.1 – 4.3
61 HC 566, para 90
While we are closing 90% of all cases received within 12 months, complicated cases that require a hearing take longer. For example, where we are waiting for the outcome of criminal investigations and legal proceedings.

We have an on-going programme of improvements to ensure our processes remain fit for purpose. Some of the improvements include:

- the launch of a new online complaint form, which makes it easier for complainants to provide the right information at the right time.
- improvements to the information we provide to complainants and referring organisations
- improvements to the way we monitor and track individual cases
- the development of a new process for handling complaints which would be more appropriately dealt with at a local level. 62

48. The GMC also said that deploying Employer Liaison Advisers and “pilots of meetings with doctors and complainants during an investigation, should result in an improved and in many cases quicker process”63.

**Audit of Fitness to practise cases**

49. In December 2013 the PSA published the findings of an audit it had conducted of the GMC’s initial stages fitness to practise process. The PSA audited 100 cases that were closed in their initial stages and assessed whether in closing the cases the GMC achieved the aim of protecting patients, service users and the public.64

50. The PSA audit uncovered deficiencies in almost a quarter of the cases they reviewed, but in only 5 cases did they raise concerns about the final decision made in a fitness to practise case. The PSA’s summary of their findings said:

The 100 cases that we reviewed in our audit showed that the GMC has maintained its effective casework system. Our overall conclusion is that the GMC’s initial stages fitness to practise process protects the public and maintains public confidence in regulation. We also identified a number of examples of good practice by the GMC in its handling of cases. However, we found weaknesses or areas for improvement in 22 of the cases that we audited, including five cases in which sufficient reasons for the GMC’s decisions were not adequately communicated to third parties. We did not

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62 GMC (GMC 02) para 31
63 GMC (GMC 02) para 32
64 PSA (GMC 03) para 3.1
have any concerns about the GMC’s actual decisions in the remaining 17 cases.  

51. The PSA’s examination highlighted the failure to provide complainants with clear or adequate reasons for closing investigations in a number of cases. The audit found:

- nine cases in which insufficiently detailed reasons for decisions were recorded, or inadequate reasons were communicated to relevant parties. In eight of the nine cases the GMC decision makers (both case examiners and other GMC staff) had not, in our view, provided adequate reasons for their decisions. While we do not consider that the decisions to close these cases failed to protect the public, we consider that the decisions would have been strengthened had clearer and more detailed reasons been documented.

In oral evidence, Niall Dickson explained that in cases where a doctor accepts the case against them the GMC “would make absolutely sure that it was known to the complainant. We would contact them and make sure they were informed of the action that had been taken.”

52. In addition the PSA found flaws in the GMC’s information-gathering processes. The audit “identified four cases […] where we considered that the GMC’s information-gathering could have been improved.” The PSA cited the example of an investigation where:

- We were concerned that the new information might have demonstrated a pattern of behaviour by the doctor, and that the GMC had not taken the opportunity to investigate whether or not that was in fact the case.

Another case highlighted by the PSA focused on the decision by the GMC to progress an investigation under their stream 2 processes which “are for cases that do not appear to raise a question about a doctor’s fitness to practise.” In this case, the PSA did not call in to question the GMC’s eventual findings, but they expressed concern that in a case where a patient had died, because it was a stream 2 investigation, “neither the post mortem report nor the patient’s medical records were obtained by the GMC.” The PSA reported that the GMC had assured them that they have explored improved methods of triaging investigations and the PSA will examine this in their next audit.

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65 Professional Standards Authority, Audit of the General Medical Council’s initial stages fitness to practise process, December 2013, para 1.8
66 Ibid, para 2.14
67 Q58
68 PSA, GMC Audit, para 2.10
69 PSA, GMC Audit, para 2.11
70 Ibid, para 1.17
71 Ibid, para 2.12
72 Ibid
53. The Committee is satisfied with the Professional Standards Authority’s overall conclusion that the GMC’s processes protect the public. The Committee believes that failures to provide complainants with clear or adequate reasons for closing investigations must be addressed as a priority if the GMC’s fitness to practise processes are to be regarded as fair and transparent. It is essential that complainants are presented with a comprehensive justification for the decisions that are reached, especially in cases where investigations are closed without sanction. Failing to achieve this will undermine public confidence in the GMC.

54. Clarifying the procedures for allocating investigations between stream 1 and stream 2 would also help to instil greater public confidence in the GMCs fitness to practise processes. The Committee expects the GMC to review its fitness to practise procedures as a result of the PSA’s audit. The GMC should seek to ensure that in future audits no cases are called in to question because their triaging meant key information was not gathered.

Sanctioning registrants without fitness to practise hearings

55. In oral evidence in 2012 the GMC told the Committee that they were preparing to pilot a new scheme whereby doctors under investigation in a clear-cut case could agree a sanction without referral to the Medical Practitioner Tribunal Service (MPTS). The GMC said it was considering this on the basis that it “could speed up procedures and conserve resources.”

56. The Committee’s report of the 2012 accountability hearing noted that there:

- is a potential reputational risk to the GMC and the medical profession more widely if the perception is established that doctors are able to accept the facts of a charge and negotiate a sanction without any appearance before a panel or the presentation of any evidence in public.

We note the proposal to pilot arrangements where a doctor may accept a sanction in a ‘clear-cut’ case without requiring a panel hearing. We recommend that the GMC evaluate such pilots carefully to ensure that there is no detriment to the public interest in not holding a hearing, and publish detailed and clear guidance on the circumstances in which such a procedure may be considered appropriate.

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73 HC 566, para 87
74 Ibid, para 87–88
In their response to the Committee’s 2012 report the GMC said that it is difficult to make the case to hold a hearing in relation to investigations where the doctor accepts both “that there is a problem with their practice and the proposed action needed to protect patients.”

57. In written evidence submitted in advance of the 2013 accountability hearing, the PSA echoed this view and said that they shared the Committee’s concerns. Their evidence said that applying sanctions to avoid holding fitness to practise hearings:

> can have some drawbacks in terms of transparency, which will only be magnified if decision makers do not provide clear evidence that they have given due account to all the relevant factors in reaching a decision that consensual disposal is the appropriate outcome.

> While the Authority supports in principle schemes that seek to conclude cases in an effective and proportionate manner, we agree with the Committee that procedural changes should be implemented with clear guidance and decision making protocols that demonstrate that they are being used appropriately.

> For example, the GMC can agree undertakings with a doctor without the need to go to a panel hearing. Some registrants may have an interest in accepting whatever the GMC propose by way of undertakings, in order to bring the matter to a close. Therefore it is not appropriate to assume that in accepting the offer of undertakings the doctor has demonstrated insight, and has an adequate understanding of what went wrong and what needs to change in the future. Doctors are required to cooperate with their regulator, so such cooperation in itself cannot be used to establish insight.

> We think it is essential that there are clear criteria embedded in these procedural changes that test for evidence of a doctor’s insight, beyond the fact that they are willing to accept undertakings. We would expect the GMC is able to show it has gathered evidence that a doctor had demonstrated insight into the shortcomings of their practice.

58. In oral evidence the GMC said the main measure of success for this scheme is the registrant accepting the proposed sanction rather than forcing the investigation to conclude with a hearing. Niall Dickson told the Committee that “[a]s far as the meetings with doctors are concerned, the measure of success would be where doctors accepted our sanction.” Mr Dickson added that the GMC is:

> proposing that the Professional Standards Authority is able to audit all our decisions in this area so it is able to see and judge whether we are making the
appropriate sanction based on the evidence. It is important that there is external scrutiny of that process.\textsuperscript{78}

59. Niall Dickson recognised, however, that the reaction of doctors to the opportunity to avoid fitness to practise hearings should only be one measure of success, he said:

It is a combination of things. If doctors accept the sanctions, we are shortening the process and they are feeling better about the process as a result, and if witnesses are not put through the trauma of having to appear in front of a hearing and we are succeeding in protecting the public, those are certainly the aims we would hope for as a result of the pilot.

Allied to this, Mr Dickson told the Committee that the GMC would meet with complainants at the beginning and end of investigations in order to find out their views regarding the process.\textsuperscript{79} Niall Dickson also assured the Committee that once sanctions are placed on a doctor’s practice the GMC has “a whole team of people who spend their whole time finding out and checking that the doctor is doing the things that [...] we have required of them.”\textsuperscript{80}

60. Although the pilot programme had yet to be completed, the GMC said in oral evidence that they believed the “early results are positive”.\textsuperscript{81} They observed, however, that legislative change is required for penalties such as suspension or erasure to be levied without recourse to a fitness to practise hearing.\textsuperscript{82}

61. The Committee believes that scheme for imposing sanctions without full fitness to practise hearings can only be regarded as successful if the registrant can demonstrate that they have genuinely learnt from the experience and changed their practice as a result of the sanction. Although safeguards are in place to check that sanctions are being adhered to, we remain concerned that registrants may accept sanctions to avoid full fitness to practise hearings without demonstrating that they fully understand and accept their own failings. In their analysis of the pilot scheme, the GMC must examine whether those doctors subject to sanctions have demonstrated an understanding of their own failings and changed their professional practices as a consequence.

62. To inspire public confidence, the scheme must not be regarded an easy mechanism for concluding cases quickly, or a process which allows registrants to escape the scrutiny of a fitness to practise hearing. The Committee accepts the GMC’s argument that allowing tougher sanctions to be levied without recourse to a full hearing would strengthen the process and help to prevent it being seen as a soft option.

\textsuperscript{78} Q54
\textsuperscript{79} Q55
\textsuperscript{80} Q57
\textsuperscript{81} Q53
\textsuperscript{82} Q53
Medical Practitioners Tribunal Service

63. The Medical Practitioners Tribunal Service (MPTS) commenced in June 2012 as a service which is operationally independent of the GMC complaint handling, investigation and case presentation functions. This fulfilled an undertaking given by the GMC in 2011 that it would make a clear separation between its role of investigator and presenter of cases and the adjudicator on those cases.

64. The GMC’s written evidence stated that since June 2012 the MPTS has “made independent decisions in more than 3,000 Interim Order Panel hearings and more than 500 Fitness to Practise hearings.” They noted that the MPTS is recruiting new lay panellists and are focussing their search on people with legal qualifications and they said the aim is to “use more legally qualified chairs who will be able to take a more active [role] in case management, ensuring that time is not wasted by any of the parties involved.”

65. In the report of the 2012 accountability hearing, the Committee welcomed the emphasis placed by His Honour David Pearl, Chair of the MPTS, on “consistency in decision making, the effective management of its cases and the dissemination of best practice.” The Committee also welcomed the Government’s commitment that they would legislate to allow the GMC to appeal against decisions made by the MPTS.

Consistency in decision making

66. Examining the steps taken by the MPTS to improve consistency in decision making, HHJ Pearl outlined a number of initiatives. He told the Committee that:

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

As to the second development, we have instituted a training programme for all of our panel members, both the long-standing ones and the new ones. [...] That is a very regular training programme [...] where we look at all of the trends in case law and the procedures to ensure we have consistency.

The third very important introduction is a system of mentoring for newly appointed members and appraisal, especially for our chairs. I and some of my colleagues sit in on and observe many of the hearings, including the "in

83 GMC (GMC 02) para 33
84 Ibid, para 34
85 HC 566, para 95
camera” discussions that take place, to ensure that there is consistency in the way in which the panels are discussing cases.\textsuperscript{86}

67. HHJ Pearl also made clear that the MPTS has examined how it communicates its findings and conclusions to the various parties involved in each case. He said:

> It is very important that when the panel reaches a decision it gives very clear reasons, obviously for the doctor but also for the profession at large, the complainant and indeed the GMC, because that is the body bringing the case. We publish those decisions. Everybody has a way of seeing exactly the way in which the panel has reached its decision.\textsuperscript{87}

Beyond communication with interested parties, HHJ Pearl also sought to emphasise the external assessment of MPTS decision making. He noted that in cases where the panels’ decisions have been reviewed they have not been reversed:

> Measurement is always rather difficult in this particular area. No two cases are exactly alike, but it is at least reassuring to know that, when doctors have taken cases to the High Court on appeal under section 40 of the Medical Act, certainly in the last six months or so, the decisions of the panel on the findings of fact, impairment and any sanction they have imposed have by and large been upheld. The most recent cases have upheld the decisions of the panel, so there is an external review of what is going on.\textsuperscript{88}

**The GMC’s right of appeal**

68. In their response to the Committee’s report of the 2012 accountability hearing the Government said that they were exploring the proposal to allow the GMC to appeal MPTS decisions. The response noted that the GMC believed that such a reform would “enhance its independence from the decisions of the MPTS and allow them to challenge panel decisions that they believe are too lenient”\textsuperscript{89}, but understood that the PSA had expressed concerns about how the system would operate in practice. In their original response to the Committee’s 2012 report, the GMC said they hoped the legislation “might be introduced by the middle of 2014”\textsuperscript{90}.

69. In oral evidence, however, the GMC revealed that the Government would not legislate in 2014 to give the GMC the right to appeal MPTS decisions. Professor Sir Peter Rubin told the Committee that:

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\textsuperscript{86} Q70  
\textsuperscript{87} Q70  
\textsuperscript{88} Q70  
\textsuperscript{89} Department for Health, Government Response to the House of Commons Health Committee Report of Session 2012-13: 2012 accountability hearing with the General Medical Council, February 2013, p 5  
\textsuperscript{90} HC 1110, p 12
As we were leaving the office today, I received a letter from the Parliamentary Under-Secretary of State for Health indicating that the section 60 order [...] will not progress in 2014 but will be incorporated within the Bill as a result of the Law Commission inquiry.91

In his letter to Sir Peter, Dr Daniel Poulter MP, Parliamentary Under-Secretary of State for Health, explained that the timetable for implementation of the proposed section 60 order would overlap with the proposed Law Commission Bill implementing reforms of professional health and care regulators. The Law Commission said in 2012 that a draft of a Bill to implement the recommendations it made in its final report would be published alongside the report in 2014.92 The Government in turn said reforms to give the GMC the right to appeal against MPTS orders would be introduced as part of the Law Commission Bill in the 2014–15 parliamentary session.93 In his letter to the GMC, the Minister said that should the Law Commission Bill not receive Royal Assent by April 2015 then the Government would revert to a section 60 order.94

70. It is disappointing that the proposal to implement regulatory reforms which would allow the GMC to appeal Medical Practitioner Tribunal Service (MPTS) decisions are not be introduced by section 60 order in 2014. Given the number of cases adjudicated each year, the Committee believes that the Government should have prioritised the introduction of the section 60 order in 2014 in order to implement the provisions at the earliest opportunity.

71. With the expectation that the next parliamentary session will see pre-legislative scrutiny of the draft Law Commission Bill, rather than the passage of a Bill through Parliament, the Government’s legislative timetable appears to be exceedingly optimistic. The Committee is concerned that incorporating the right to appeal in a draft Law Commission Bill will only further delay implementation, as there is little likelihood of Royal Assent before the end of the Parliament. Therefore, the Committee urges Ministers to use a section 60 order to implement the GMC’s right to appeal MPTS decisions as soon as is reasonably practicable.

Registrants with criminal convictions

72. In November 2013 it was reported that hundreds of doctors with criminal convictions were still practising in the UK. The Daily Telegraph reported that:

The General Medical Council (GMC) released the number of criminal records held by practising doctors in response to a Freedom of Information

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91 Q71
92 Law Commission, Regulation Of Health Care Professionals, March 2012, para 1.35
93 Department of Health, Letter from Dr Daniel Poulter MP, Parliamentary Under-Secretary of State for Health, December 2013
94 Letter from Daniel Poulter MP, December 2013
request. It showed 761 doctors were practising in October this year, despite accumulating 856 convictions between them.

They included one doctor who took indecent photographs of a child, two with convictions for possessing child pornography, two for trafficking drugs and three for grievous bodily harm. There were 31 offences of assault, three of possessing dangerous weapons, seven for soliciting prostitutes, a dozen for domestic violence, and two of child cruelty or neglect.95

The GMC’s written evidence confirmed these figures. The GMC noted that of the 761 doctors licensed to practise who have a criminal conviction, 590 convictions related to driving offences.96

73. In their written evidence the GMC said that:

Any doctor who receives a custodial sentence is automatically referred to the Medical Practitioner Tribunal Service (MPTS), which now hears all cases pursued by the GMC. [...]

Most doctors with serious criminal convictions are removed from the medical register or suspended for a time and most can only return to work under strict conditions.97

Other than in the most extraordinary circumstances, the GMC will always call for the doctor to be removed from the register in cases where there is a serious conviction such as sexual misconduct and serious dishonesty98.

They added that there are “14 licensed doctors on our register who we called for to be erased since 2008; 11 of these were suspended, 1 received undertakings and 2 received a warning.”99

74. The GMC’s written evidence emphasised the importance of the right to appeal decisions taken by the Medical Practitioner Tribunal Service (MPTS). In addition the GMC is seeking the:

powers to remove doctors from the register without the need for a hearing if they have committed very serious offences which are incompatible with practising as a doctor. Under our rules and legislation only a fitness to practise panel can remove a doctor from the register. In order to be compliant with human rights legislation a doctor would have a right to make representations which we would consider prior to removing their name from

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95 “Hundreds of convicted doctors still practising”, The Daily Telegraph, 24 November 2013
96 GMC (GMC 026) p1
97 Ibid
98 Ibid
99 Ibid
the register but a hearing would not be necessary. We have consulted on this and now just need the legislation to do it.\textsuperscript{100}

75. In oral evidence the GMC told the Committee that those doctors who remain on the register having been convicted of very serious offences (including sexual offences) do so because the cases were adjudicated in 2004 and 2006 and current practice would be different.\textsuperscript{101} Niall Dickson told the Committee that the GMC would always call for erasure in very serious cases such as the possession indecent images of children. HHJ Pearl said that he would be “most concerned” if a doctor with a conviction in such a case was allowed to continue to practise as a doctor.\textsuperscript{102} Mr Dickson added:

To be absolutely clear, the leadership of the General Medical Council and all its bits would absolutely, every time, in the instances you are referring to, want to see the doctor erased. If you give us the right of appeal and the panel does not, we will do it. This is not a debatable issue.\textsuperscript{103}

76. The Committee believes that carrying a conviction for a serious violent or sexual offence is incompatible with being a doctor. We welcome the GMC’s commitment to pursue the most severe sanctions against registrants convicted of such offences. This issue illustrates the importance of legislation being implemented to allow the GMC to appeal Medical Practitioner Tribunal Service decisions. Whilst His Honour Judge Pearl’s comments were reassuring, it is vital that the GMC is able to challenge panel judgements which may be too lenient or incompatible with professional practice. Similarly, implementing the legislative reform to allow the GMC to remove doctors from the register without recourse to a full fitness to practise hearing will enable the GMC to act in the interests of the public and the profession without undue delay.

\textbf{Language competence of licensed doctors}

77. In its report of the 2012 accountability hearing the Committee welcomed the proposal that would allow the GMC to test language competence in cases where specific concerns regarding doctors’ language skills had been identified.\textsuperscript{104} In their written evidence, the GMC described how policy related to language testing had developed since the 2012 accountability hearing. Their submission said:

The Department of Health has agreed to put proposals to parliament to amend the Medical Act next year which will allow us to check the language skills of doctors from the European Economic Area after the point of registration but before granting a licence to practise. The Department of

\textsuperscript{100} Ibid
\textsuperscript{101} Q68
\textsuperscript{102} Q68
\textsuperscript{103} Q68
\textsuperscript{104} HC 566, para 56
Health and the GMC are currently consulting on these proposals which would allow us to do so in cases where we have concerns about a doctor’s knowledge of English.

We are pleased that following engagement from the GMC and other regulators in Europe the new directive will now contain significant improvements which will enhance patient safety. In particular the revised text of the Recognition of Professional Qualifications Directive now states that competent authorities - such as the GMC - should have explicit powers to assess the language competency of all health professionals after their qualifications have been recognised but before they are allowed to practise. The new Directive will need to be transposed into UK law by the end of 2015. At this point the GMC should be able to introduce a more comprehensive scheme for language controls before doctors are given a licence to practise in the UK.

78. The Government confirmed on the 9 September 2013 that it had launched a consultation on amending the Medical Act 1983 in order to implement language controls for doctors. The consultation highlighted the extent of the problem.

The GMC has provided the Department with figures which show that in 2012 there were ten fitness to practise cases concluded by the GMC, which involved concerns about the language skills of doctors from within the European Economic Area (EEA). In addition, a survey of Responsible Officers by the England Revalidation Support Team (RST) in 2011, which covered just over half of all doctors, indicated that there were 66 cases where Responsible Officers have dealt with linguistic concerns about a doctor.105

79. The proposed controls would strengthen the ability of the GMC to launch fitness to practise proceedings by classifying a lack of knowledge of English as an impairment. The regulations would also allow for language testing as part of a fitness to practise investigation in order to gather evidence. In addition the proposals would allow:

the GMC to refuse a licence to practise to a doctor who was unable to demonstrate the necessary knowledge of English. This would apply on an application for first registration with the GMC or a subsequent application for a licence to practise if the doctor had not previously held a licence.106

The consultation also included a proposal that the regulations include an “explicit duty, in legislation, on Responsible Officers to ensure English language competence as part of the recruitment process.”107

105 Department of Health, Language Controls for Doctors - Proposed Changes to the Medical Act 1983, A paper for consultation, 7 September 2013, p 8
106 Ibid, p 12
107 Ibid, p 6
80. In oral evidence Sir Peter told us that he had received assurance from the Department of Health that the amendment to permit language testing “will progress in April 2014”\textsuperscript{108}. Additional written evidence submitted by the GMC said that in 2013 the GMC “made decisions on 13 fitness to practise cases where a doctor’s knowledge of English formed a significant element of the concerns raised with us.”\textsuperscript{109} This represents a slight increase on 2012.

81. The Committee welcomes the fact that the Government is legislating to allow the language testing of registrants from the European Economic Area in cases where a doctor’s communications skills are of concern. This represents an important development in improving public protection as both Government and GMC data shows that language concerns have been prevalent in fitness to practise cases. The Committee notes that responsible officers will be tasked with identifying concerns and undertaking testing. In their assessment of the performance of responsible officers the GMC should evaluate whether they are sufficiently close to their registered doctors to make informed decisions concerning their ability to communicate with their patients.

\textsuperscript{108} Q71

\textsuperscript{109} GMC (GMC 027) p 3–4
5 Doctors’ participation in research

Register of doctor’s interests

83. In advance of the accountability hearing the Committee received a number of submissions concerning the participation of doctors in medical research and the declaration of interests in such cases. Margaret McCartney, a GP in Glasgow and broadcaster on BBC Radio 4’s Inside Health said in her evidence:

> At the moment I can find out what financial conflicts of interest my MP has. But I can’t find out what potential COIs my doctor has—and my patients can’t find out that about me easily (though they have been listed for some time on my blog). So when a doctor prescribes me a drug, I’d like to know whether they are a paid consultant to that drug company, whether they have received education from that drug company, etc. [...] Doctors have to pass appraisals every year when ‘probity’ issues are discussed. Why can’t that information be held by the GMC for patients to check, just as they can to see if that doctor is registered with them or not?\(^{110}\)

84. Commenting on the suggestion that the GMC should hold a public register of doctor’s interests, Sir Peter Rubin told the Committee that at present the public would not know if a doctor has a financial conflict of interest.\(^{111}\) Niall Dickson gave a commitment on behalf of the GMC that they would examine the possibility of operating a register of interests as “part of our wider look at how we can make the register as useful as possible.”\(^{112}\)

85. The Committee believes that there is a compelling case for the GMC to hold a public register of doctors’ interests with the responsibility for maintaining the accuracy of the register sitting with registrants. Although the Committee welcomes the fact that the GMC is willing to explore this, we believe that the regulator should examine the practical considerations of developing a register which is reliable and open to public scrutiny. At our next accountability hearing the Committee will ask the GMC to outline its progress in this area in detail.

Publication of research findings

86. The evidence submitted by Dr Ben Goldacre, Sir Iain Chalmers, Dr Trish Groves, Dr Fiona Godlee and Dr Virginia Barbour backed the view that the GMC should maintain a register of doctors’ interests. They did not argue against doctors participating in commercial medical research, however, their submission did state that:

\(^{110}\) Margaret McCartney (GMC 09) para 2

\(^{111}\) Q79

\(^{112}\) Q77
there is extensive research evidence showing that doctors with financial conflicts of interest often express more favourable views on the treatments in question, when compared to doctors who have not received such payments. It is therefore important that information about these conflicts of interest is transparent. It is currently extremely hard - and in many cases impossible - for patients, colleagues, patients and the public to establish who has paid a doctor.\textsuperscript{113}

87. Their evidence noted that the “GMC do good work on misdeeds by individuals in individual studies”. Their submission concluded, however, that the GMC should:

clarify their position, and strengthen the wording of their guidance, requiring that any doctor working on a trial both past and present - on all treatments currently in use–is responsible for ensuring that the trial is registered, with its results made publicly available within a year of completion; and forbidden from entering into contracts with trial sponsors that relinquish access to data and prevent dissemination of results.\textsuperscript{114}

The overriding concern expressed in their written evidence was that whilst the GMC has been able to tackle cases whereby doctors have participated in fraudulent studies there are no mechanisms to reveal the outcomes of studies with unflattering results.

This view was echoed by Sense about Science who argued that all medical trials should be registered and “full methods and summary results reported.”\textsuperscript{115} They concluded that the GMC should:

have a role in ensuring that doctors working on clinical trials or who worked on a clinical trial in the past on any treatment in current use ensure that the clinical trial has been registered and a summary of the findings is publicly available.\textsuperscript{116}

88. The GMC took an assertive stance in discussing the requirement to publish the outcomes of research and clinical trials. Sir Peter Rubin observed that advances in the ability to publish findings means that there are no longer legitimate reasons for failing to publicise negative results. He told the Committee that:

There was a time when it was very difficult to get negative studies published in peer review journals, so a doctor, try as he might, just could not get it published. Now, with open access, you can put your results online and they are there without peer review. The landscape has changed, and there is now

\textsuperscript{113} Dr Ben Goldacre et al, (GMC 19) p 1
\textsuperscript{114} Ibid
\textsuperscript{115} Sense About Science, (GMC 21) para 3
\textsuperscript{116} Ibid, para 11
no justification for negative, seemingly boring, results to be withheld; they can be put into the public domain.117

The GMC stated clearly that it is incompatible with their guidance for a registrant to suppress research findings.118 Professor Sir Peter Rubin and Niall Dickson both described how the GMC is preparing to alter the guidance available in Good Medical Practice because the shortened version did not directly address the issue of transparency in medical trials.119 Sir Peter Rubin noted that the GMC’s supplementary guidance did address this issue, but the question of transparency was “implicit but not explicit in that guidance”.120

89. The Committee welcomes the GMC’s recognition that the contemporary research landscape no longer offers any valid justification for failing to publish the results of negative drug trials. The Committee believes it is now essential that the GMC re-words its guidance so that the need for transparency is made explicitly clear. The GMC’s written evidence showed that there have been a small number of fitness to practise cases resulting from doctors failing to publish the results of medical trials.121 It is essential that all registrants are made aware by the GMC that the failure of a doctor to ensure publication of the results of medical trials constitutes a serious breach of professional obligation.

117 Q84
118 Q85
119 Q81– Q82
120 Q81
121 GMC (GMC 027) p 5
Conclusions and recommendations

Managing professional concerns

1. The GMC now fields significantly more complaints regarding the practice of registrants than it did even five years ago. The Committee accepts that this trend is not exclusive to doctors, or even the medical profession as a whole, but we believe the GMC must now seek to better understand what has driven these complaints and the detail behind them. In advance of the Committee’s next accountability hearing with the GMC the GMC should report on:

- The profile of complainants and those who have had complaints made against them;
- Trends in the triggers or stimuli which prompt registrants to report concerns regarding other doctors;
- The impact of revalidation and the degree to which this has prompted medical directors to refer doctors to the GMC;
- The extent to which complaints are vexatious or made in response to an earlier complaint;
- The relationship between complaints made to the GMC by registrants and the ability of registrants to raise concerns with their own employers. (Paragraph 10)

2. In oral evidence the GMC discussed the relationship that exists between referrals made to them by registrants, the willingness to doctors to flag their concerns locally and the ability of employers to manage those concerns. The Committee believes that the GMC should examine carefully whether high rates of referrals from a particular organisation indicates a willingness to refer concerns to the appropriate national regulator or an inability of local systems to act on professional concerns. In the long-term, the GMC should play a leading role in helping the Government and NHS England to understand the relationship between patient complaints, the ability of registrants to raise concerns and a provider’s workplace culture. (Paragraph 11)

3. The Committee believes that the GMC’s national training survey and confidential helpline both represent useful mechanisms for registrants to report professional concerns, but these resources will not in themselves perpetuate a change in professional culture. It is equally important that the GMC concentrates its efforts on ensuring that a doctor’s professional environment permits the raising and discussion of concerns within the workplace. As part of this, the GMC should reiterate to all of its registrants that they not only have a professional obligation to report concerns when they arise, but also to act to address problems if concerns are reported to them and that failure to do so raises issues of professional discipline. (Paragraph 16)
4. The GMC observed in oral evidence that its responsibilities in relation to training means that it is more than just a professional regulator and it also has a responsibility as a system regulator to oversee elements of the system which operate across the UK. It must now begin to consider how it can formally contribute the knowledge and data gained from this role to the wider management and regulation of UK health services. (Paragraph 17)

**Revalidation**

5. Revalidation has only been in operation for a little over 12 months and as yet the data does not exist to explain whether it is a fundamentally better process to identify and address failings in professional practice than the previous system which relied solely on employer led appraisals. From the perspective of employers, this process should be about more than simply helping their staff navigate revalidation and should embrace ongoing appraisal and the management of poor performance. Una Lane’s comments in this regard are encouraging, but at our next accountability hearing the Committee would like to see a formal assessment of the evidence relating to revalidation to ensure that it is making a significant contribution to the improved practice of doctors. (Paragraph 22)

6. The Committee notes that the tone and emphasis around responsible officers has altered as revalidation has been launched. The implication of the GMC’s most recent remarks appears to be that responsible officers may not be held to account for a doctor’s performance on an individual basis in the same way as was originally envisaged. The Committee is concerned about this development and recommends that the GMC should clarify precisely the nature of the personal responsibility of the responsible officer. (Paragraph 26)

7. The GMC’s commentary in relation to responsible officers suggests that whilst the responsible officer may embody the statutory obligations of an organisation, it is the organisation as a whole that must make sure that the resources are in place to meet its obligations in relation to revalidation. Therefore, any analysis of the success of responsible officers in overseeing revalidation must go beyond a basic assessment of the ratio of responsible officers to doctors and examine the overall resources deployed by the designated body. Nevertheless, the ability of each responsible officer to form the necessary professional relationship with the doctors they oversee will, in part, be determined by the total number of doctors they are required to support. The Committee is concerned that changes to the management structure of the NHS must not be allowed to undermine the effectiveness of professional regulation. (Paragraph 31)

8. As part of their analysis of revalidation, the GMC should review the way in which responsible officers relate to individual doctors in order to ensure that responsible officers are able to discharge their responsibilities effectively on behalf of patients. This analysis should help to determine whether the number of responsible officers available is sufficient to properly oversee the work of doctors. (Paragraph 32)
9. The Committee is pleased that significant progress has been made in ensuring that employers develop formal plans to improve the skills of the medical staff and address flaws in their practice. We believe that the GMC should continue to monitor the commitment of employers to effective remediation as well as examining why approximately 15% of employers have still not complied with the principles of good practice. The Committee is concerned that 15% of employers have not complied with this basic element of good practice. (Paragraph 37)

10. In oral evidence the GMC made it clear that Employer Liaison Advisers are not part of the formal accountability structure for responsible officers. However, the Committee notes the significance the Professional Standards Authority has attached to the role of Employer Liaison Advisers in prompting medical directors to refer doctors about whom they have concerns. (Paragraph 40)

11. The Committee agrees with the GMC that the successful incorporation of patient feedback into the process of revalidation depends on more than just the regularity by which feedback is required. The quality and applicability of feedback is crucial as the information has to be able to inform and improve a doctor’s practice. The challenge for the GMC is to begin to develop more sophisticated mechanisms for incorporating the views of patients into revalidation. At our next accountability hearing with the GMC we shall seek specific evidence about the regularity and effectiveness with which patient feedback is incorporated into the revalidation process. (Paragraph 43)

Fitness to practise

12. The Committee is satisfied with the Professional Standards Authority’s overall conclusion that the GMC’s processes protect the public. The Committee believes that failures to provide complainants with clear or adequate reasons for closing investigations must be addressed as a priority if the GMC’s fitness to practise processes are to be regarded as fair and transparent. It is essential that complainants are presented with a comprehensive justification for the decisions that are reached, especially in cases where investigations are closed without sanction. Failing to achieve this will undermine public confidence in the GMC. (Paragraph 53)

13. Clarifying the procedures for allocating investigations between stream 1 and stream 2 would also help to instil greater public confidence in the GMC’s fitness to practise processes. The Committee expects the GMC to review its fitness to practise procedures as a result of the PSA’s audit. The GMC should seek to ensure that in future audits no cases are called in to question because their triaging meant key information was not gathered. (Paragraph 54)

14. The Committee believes that scheme for imposing sanctions without full fitness to practise hearings can only be regarded as successful if the registrant can demonstrate that they have genuinely learnt from the experience and changed their practice as a result of the sanction. Although safeguards are in place to check that sanctions are being adhered to, we remain concerned that registrants may accept sanctions to
avoid full fitness to practise hearings without demonstrating that they fully understand and accept their own failings. In their analysis of the pilot scheme, the GMC must examine whether those doctors subject to sanctions have demonstrated an understanding of their own failings and changed their professional practices as a consequence. (Paragraph 61)

15. To inspire public confidence, the scheme must not be regarded an easy mechanism for concluding cases quickly, or a process which allows registrants to escape the scrutiny of a fitness to practise hearing. The Committee accepts the GMC’s argument that allowing tougher sanctions to be levied without recourse to a full hearing would strengthen the process and help to prevent it being seen as a soft option. (Paragraph 62)

16. It is disappointing that the proposal to implement regulatory reforms which would allow the GMC to appeal Medical Practitioner Tribunal Service (MPTS) decisions are not be introduced by section 60 order in 2014. Given the number of cases adjudicated each year, the Committee believes that the Government should have prioritised the introduction of the section 60 order in 2014 in order to implement the provisions at the earliest opportunity. (Paragraph 70)

17. With the expectation that the next parliamentary session will see pre-legislative scrutiny of the draft Law Commission Bill, rather than the passage of a Bill through Parliament, the Government’s legislative timetable appears to be exceedingly optimistic. The Committee is concerned that incorporating the right to appeal in a draft Law Commission Bill will only further delay implementation, as there is little likelihood of Royal Assent before the end of the Parliament. Therefore, the Committee urges Ministers to use a section 60 order to implement the GMC’s right to appeal MPTS decisions as soon as is reasonably practicable. (Paragraph 71)

18. The Committee believes that carrying a conviction for a serious violent or sexual offence is incompatible with being a doctor. We welcome the GMC’s commitment to pursue the most severe sanctions against registrants convicted of such offences. This issue illustrates the importance of legislation being implemented to allow the GMC to appeal Medical Practitioner Tribunal Service decisions. Whilst His Honour Judge Pearl’s comments were reassuring, it is vital that the GMC is able to challenge panel judgements which may be too lenient or incompatible with professional practice. Similarly, implementing the legislative reform to allow the GMC to remove doctors from the register without recourse to a full fitness to practise hearing will enable the GMC to act in the interests of the public and the profession without undue delay. (Paragraph 76)

19. The Committee welcomes the fact that the Government is legislating to allow the language testing of registrants from the European Economic Area in cases where a doctor’s communications skills are of concern. This represents an important development in improving public protection as both Government and GMC data shows that language concerns have been prevalent in fitness to practise cases. The
Committee notes that responsible officers will be tasked with identifying concerns and undertaking testing. In their assessment of the performance of responsible officers the GMC should evaluate whether they are sufficiently close to their registered doctors to make informed decisions concerning their ability to communicate with their patients. (Paragraph 81)

**Doctors’ participation in research**

20. The Committee believes that there is a compelling case for the GMC to hold a public register of doctors’ interests with the responsibility for maintaining the accuracy of the register sitting with registrants. Although the Committee welcomes the fact that the GMC is willing to explore this, we believe that the regulator should examine the practical considerations of developing a register which is reliable and open to public scrutiny. At our next accountability hearing the Committee will ask the GMC to outline its progress in this area in detail. (Paragraph 5)

21. The Committee welcomes the GMC’s recognition that the contemporary research landscape no longer offers any valid justification for failing to publish the results of negative drug trials. The Committee believes it is now essential that the GMC rewords its guidance so that the need for transparency is made explicitly clear. The GMC’s written evidence showed that there have been a small number of fitness to practise cases resulting from doctors failing to publish the results of medical trials. It is essential that all registrants are made aware by the GMC that the failure of a doctor to ensure publication of the results of medical trials constitutes a serious breach of professional obligation. (Paragraph 89)
Draft Report (2013 Accountability hearing with the General Medical Council), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 89 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Tenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

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[Adjourned till Tuesday 1 April at 2.00 pm]
Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee’s inquiry page at http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/general-medical-council-2013/?type=Oral#pnlPublicationFilter.

Tuesday 10 December 2013

Professor Sir Peter Rubin, Niall Dickson, Una Lane and His Honour David Pearl
General Medical Council Q1-88
Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/general-medical-council-2013/?type=Written#pnlPublicationFilter. GMC numbers are generated by the evidence processing system and so may not be complete.

1. General Medical Council (GMC0002)
2. Professional Standards Authority (GMC0003)
3. Dr Jennifer Colman (GMC0004)
4. The Royal College of Radiologists (GMC0005)
5. Mencap (GMC0006)
6. Narinder Kapur (GMC0007)
7. Dr Es Miller (GMC0008)
8. Margaret Mccartney (GMC0009)
9. Eifion Edwards (GMC0010)
10. David Carroll (GMC0012)
11. Dr Umesh Prabhu (GMC0013)
12. Mrs Daphne Havercroft (GMC0014)
13. Patients First (GMC0015)
14. David Tredrea (GMC0017)
15. Private Eye (GMC0018)
16. Ben Goldacre (GMC0019)
17. Sense About Science (GMC0021)
18. Carl Reynolds (GMC0022)
19. Doctors4justice (GMC0023)
20. Dr Ravindra Garg (GMC0024)
21. General Medical Council (GMC0026)
22. General Medical Council (GMC0027)
## List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee’s website at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom). The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

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<td>Eighth Report</td>
<td>Annual accountability hearing with the General Medical Council</td>
<td>HC 1429 (HC 1699)</td>
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<td>Appointment of the Chair of the NHS Commissioning Board</td>
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<td>Annual accountability hearings: responses and further issues</td>
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<td>PIP Breast implants and regulation of cosmetic interventions</td>
<td>HC 1816 (Cm 8351)</td>
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