CHAPTER FIFTEEN

The General Medical Council

Introduction

15.1 As I explained in Chapter 2, the Inquiry's Terms of Reference require it, by reference to the case of Harold Shipman, to enquire into the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision and to recommend what steps, if any, should be taken to protect patients in the future. A fundamental and essential part of the monitoring of primary care provision is the business of deciding whether any doctor practising as a general practitioner (GP) is fit to continue to do so. That task is carried out by the General Medical Council (GMC), the regulatory and disciplinary body of the medical profession in the UK.

15.2 The GMC is a statutory body with responsibility for the registration of all doctors. There are two aspects to the duty of registration: one is maintaining the register; the other is deciding who shall be on it. Deciding who shall be on the register involves first laying down the educational standards to be achieved before an individual can be admitted to the register. It also involves deciding whether a doctor's name should be erased from the register or whether his/her registration should be suspended because s/he is considered to be unfit to practise as a doctor. The GMC has the power to remove doctors from the register or to suspend their registration and, as an adjunct to that power, can also restrict the registration of an individual doctor, in effect imposing conditions under which the doctor is permitted to continue to practise. The GMC exercises its powers of erasure, suspension and restriction through its 'fitness to practise (FTP) procedures', with which the following Chapters of this Report are concerned.

15.3 It is clear that, under its Terms of Reference, the Inquiry must examine the GMC's role as the regulatory and disciplinary body for persons already practising as GPs. However, it did not appear to me that Parliament intended the Inquiry to examine, at least as anything other than background, the means by which a person becomes a GP or the standards to be achieved before that can happen. The Inquiry is not, therefore, concerned with the GMC's educational responsibilities.

15.4 Shipman was admitted to the medical register in August 1971 and practised as a GP for over 22 years between 1974 and 1998. During that time, he was reported to the GMC for various forms of alleged misconduct on three occasions, in 1976, 1985 and 1994, prior to the police investigation which resulted in his conviction for murder. On each occasion, after considering the circumstances or allegations in the light of the procedures in force at the relevant times, the GMC decided to allow him to continue in practice without restriction. Plainly, the Inquiry was expected to examine those allegations, circumstances and procedures and to consider the decisions of the GMC that affected Shipman. Out of fairness to the GMC, it was obviously necessary to examine the procedures in operation at the various times when complaints were made and to consider the decisions affecting Shipman in the context of the culture of the times and against the background of the way in which the GMC usually decided such cases at those times.

15.5 However, the Inquiry also has to make recommendations for the protection of patients in future. The procedures that were in force when Shipman was last reported to the GMC have changed a great deal; indeed, as I shall explain, they have been in an almost constant state of development and change since the mid-1990s. The GMC has very recently introduced a completely new regime of FTP procedures. In order to make recommendations for the protection of patients in future, the Inquiry has had to examine the development of the FTP procedures and the GMC's 'track record' of operating them. It must also consider the new procedures, for which there exists, as yet, no operational 'track record'.

15.6 The Terms of Reference require the Inquiry to consider the actions of all those involved in monitoring primary care provision **'by reference to the case of Harold Shipman'**. Shipman was, as is now known, a serial murderer of his patients. However, it would be simplistic to suggest that the Inquiry was expected only to make recommendations about how to protect patients from being murdered by their GPs. Shipman was many other things besides a murderer. He was also a liar and a cheat. He forged prescriptions, falsified medical records and practised various other forms of dishonesty. In the 1970s, he misused pethidine, a controlled drug, by obtaining it unlawfully and administering it to himself; he was, for a time, addicted to or dependent upon that drug. Throughout his entire time in general practice, he flouted the statutory regulations relating to the keeping and usage of controlled drugs. There is also evidence that he was reckless or careless when prescribing or administering drugs. On one occasion, it was found that he had failed to attend a patient who needed admission to hospital. Thus, to consider the GMC's procedures **'by reference to the case of Harold Shipman'** requires consideration of the GMC's procedures as they affect doctors exhibiting a wide range of problems, including misconduct, ill health due to drug addiction or dependence and substandard clinical performance. For that reason, the examination which follows must necessarily be wide-ranging and detailed.

History

Objectives

15.7 The GMC was created by the Medical Act 1858. The current statute governing its constitution, functions and practices is the Medical Act 1983, as amended (the 1983 Act). Originally, the principal purpose of the GMC was to rationalise the many different forms of medical qualification then in existence and to distinguish properly qualified medical practitioners from the large number of unqualified persons who held themselves out as offering medical services. The early GMC was also given a limited disciplinary role whereby it could erase from the medical register any doctor found guilty of **'infamous conduct in a professional respect'**. From early times, there was some recognition that the underlying objective of the GMC should be to protect the public from 'rogue' doctors. However, in recent times, that objective has been much more clearly spelled out and the GMC now accepts that the protection of patients and the public must be its paramount objective. Very recently, that objective has been given statutory recognition. By section 1A of the 1983 Act, as amended in 2002, the main objective of the GMC in exercising its functions is **'to protect, promote and maintain the health and safety of the public'**. The

Charity Commissioners, in granting charitable status to the GMC in 2001, defined its purpose as being **'to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine'**. Those statements of purpose are applicable to both of the GMC's main functions, i.e. the setting of educational standards and the exercise of its disciplinary role through the FTP procedures.

Constitution

15.8 Initially, the GMC comprised 24 members (collectively termed 'the Council'), most of whom were nominated by the medical Royal Colleges and the universities. A few were chosen by the Privy Council. All were medically qualified. The numbers increased to 29 in 1886 and, from 1926, it became the practice of the Privy Council to choose at least one non-medical ('lay') member. By 1950, the GMC had 50 members, of whom three were lay members. The method of selection and appointment changed with the coming into force of the Medical Act 1978, since which time a majority of members has been elected by doctors on the medical register. Also at that time, the number of GMC members increased. By 1989, the number had grown to 102. In June 2003, there were 104 members of whom 54 were elected, 25 were appointed by the universities and the medical Royal Colleges and 25 were nominated by the Queen on the advice of the Privy Council. By law, a majority of nominated members must be persons who are not medically qualified but, in recent years, the practice has been for the Privy Council to advise that all nominated members should be lay members. All elected and appointed members are registered doctors.

15.9 In July 2003, the number of Council members was reduced to 35, comprising 19 elected medical members, two appointed medical members and 14 nominated lay members. This change was brought about as it was recognised that effective decision-making was almost impossible for a group with 104 members. This change has had the effect of increasing the proportion of lay members on the Council from about 25% to 40%.

Development: the Merrison Committee

15.10 The change to a largely elected membership came about as the result of the recommendations of a Committee set up in 1972, under the chairmanship of Dr (later Sir) Alec Merrison (the Merrison Committee). Until the late 1960s, the GMC was financed by a single registration fee paid by each doctor at the time of registration. By the 1960s, the GMC's activities and expenditure had increased and it required increased income. It decided to impose an annual retention fee on all doctors. This led to insurrection. Many doctors refused to pay the annual fee; they argued that there should be 'no taxation without representation'. The GMC threatened them with erasure. The Government was concerned at the prospect of losing a large number of NHS doctors. At the time, there were other issues dividing the GMC from various professional bodies, such as the British Medical Association and several of the Royal Colleges. In order to give proper consideration to all these issues, the Government set up the Merrison Committee. Its Terms of Reference required the Committee:

> **'To consider what changes need to be made in the existing provisions for the regulation of the medical profession; what functions should be**

assigned to the body charged with the responsibility for its regulation; and how that body should be constituted to enable it to discharge its functions most effectively; and to make recommendations.'

15.11 The Merrison Committee reported in 1975, with two main proposals. It suggested that the profession should have the right to elect a majority of the members of the GMC, a change which was, as I have said, effected by the Medical Act 1978. Today, the majority of members of the GMC are still elected by medical practitioners. This change no doubt resolved the discontent within the profession; there was now to be taxation but with representation. However, the dominance in a regulatory body of an elected group, with an electorate to serve, inevitably gives rise to conflicts of interests and objectives. Those members elected by the profession must, at least to some extent, have the interests of their electors at heart. At times, the interests of doctors and of the public may lie in different directions. Yet, as I have explained, the main objective of the GMC should be **'to protect, promote and maintain the health and safety of the public'**. Financial matters must sometimes give rise to a potential conflict between interests and objectives. The GMC is still funded by an annual retention fee payable by all doctors. By far the greatest item of expenditure in the GMC budget is the FTP procedures. The number and variety of cases going through the FTP procedures has increased enormously in recent years. The appointment of suitably educated, experienced and trained staff and panel members sufficient to administer the FTP procedures must have led to an increased financial burden.

15.12 The Merrison Committee also proposed reforms to the FTP procedures, based upon a clear statement of philosophy that these procedures were to be designed to protect patients rather than to punish doctors. In particular, it recommended new procedures for supporting and rehabilitating doctors who were unfit to practise by reason of ill health. I shall describe these procedures in Chapter 22. Whether the GMC has struck the right balance between protecting patients and supporting and rehabilitating doctors (rather than punishing them) is an issue to which I will return in subsequent Chapters.

15.13 The Merrison Committee recommended that the GMC should be statutorily charged with the duty of promoting high standards of professional conduct. The relevant powers were provided by the Medical Act 1978. The Committee also considered the possibility that the GMC might undertake some form of periodic 're-licensure' of doctors. The position then was (and still is) that, once a doctor had qualified, it was taken for granted that s/he remained fit to practise unless and until found to be unfit as the result of FTP proceedings. Those proceedings could be initiated only following the receipt by the GMC of a complaint or report about the doctor. Re-licensure would have entailed some periodic reassessment of fitness to practise. The Merrison Committee considered any recommendations in respect of re-licensure to be beyond its remit and the presumption that a doctor will remain fit to practise throughout his/her career has, therefore, continued. However, that situation is about to change under proposals that doctors' registration should be periodically 'revalidated'. It is proposed that, once every five years, every doctor who wishes to continue to hold a licence to practise will have to demonstrate to the GMC that s/he is 'up to date and fit to practise' in his/her chosen field. I shall describe those proposals in Chapter 26.

Various Functions

15.14 As I have said, the GMC function which is of most direct interest to the Inquiry is the conduct of the FTP procedures. The revalidation of the doctors' registration is also a matter of interest. However, for the sake of completeness and lest it be thought that I am unaware of the important work done by the GMC in other fields, I shall describe its other functions very briefly before describing (also briefly at this stage) the various FTP procedures. Those other functions are:

- the setting of standards of professional competence and conduct
- the registration of doctors
- the promotion of high standards in the training and education of doctors.

The Setting of Standards of Professional Competence and Conduct

15.15 The Committee on Standards of Professional Conduct and on Medical Ethics (the Standards Committee) is responsible for the GMC's work in setting standards of competence and conduct. It seeks to define the principles that underlie good professional practice, to apply those principles to new and developing situations and circumstances, and to advise the GMC on guidance which should be issued as a whole.

15.16 From its early days, the GMC provided guidance to doctors about unacceptable conduct. Until the early 1990s, the guidance largely comprised warnings about the kind of misconduct that might lead to disciplinary action by the GMC. The GMC no longer does this. Since 1995, the emphasis has changed and the GMC has sought to provide positive advice about standards of good practice and ethics. The Standards Committee has also produced, and the GMC has promulgated, a number of other sets of guidance of both a general and a specific nature.

15.17 In 1995, the GMC issued the first edition of the publication 'Good Medical Practice', which contained a statement of the principles characterising good medical practice, together with an exposition of the 'Duties of a Doctor'. I understand that doctors find this publication extremely helpful and that it has been adopted or adapted for use in many other countries. 'Good Medical Practice' is now in its third edition and is undergoing further revision. It is said to provide the standards against which doctors will be judged if their registration is called into question under the FTP procedures. The principles and duties set out in 'Good Medical Practice' are said to form the basis of the **'professional contract between doctors and their patients'**. While I readily accept that 'Good Medical Practice' provides the standards against which a doctor is judged, it is aspirational in nature. It does not provide – whether for doctors, healthcare managers or patients – clear guidance about the standards the doctor must achieve if s/he is to avoid criticism or action on registration under the FTP procedures.

The Registration of Doctors

15.18 Section 2 of the 1983 Act provides that the Registrar shall keep two registers of medical practitioners. The first comprises the names of doctors who are fully registered and the

second contains the names of doctors who are entitled to provisional or limited registration. Provisional registration allows newly qualified doctors to undertake the general clinical training needed for full registration. A doctor who is provisionally registered is entitled to work only in certain specified settings. Doctors holding limited registration may work only under the supervision of a fully registered doctor and in certain specified types of post. It is a criminal offence for any person knowingly to hold him/herself out as being a registered medical practitioner if s/he is not in fact so registered. The GMC also operates a third register, known as the specialist register, inclusion in which is a prerequisite for appointment to a substantive or honorary NHS consultant post.

15.19 The present position is that, in general, once registered, a doctor is entitled to remain on the register unless his/her name is removed by order of a FTP panel. In the future, it is the GMC's intention to issue a licence to practise to all doctors who wish to exercise the rights and privileges of the profession. Thereafter, the GMC will require all doctors who wish to retain their licence to practise to undergo revalidation. This process will be introduced in 2005, but will take several years to be fully effective.

The Promotion of High Standards in the Training and Education of Doctors

15.20 Under section 5(1) of the 1983 Act, the Education Committee of the GMC has the general functions of promoting high standards and of co-ordinating all stages of medical education. In 1993, the Committee issued the publication 'Tomorrow's Doctors – Recommendations on Undergraduate Medical Education', which contained recommendations for the implementation of a new curriculum in medical schools in the UK. In 2002, a revised version of this work was published, describing what was expected of all medical graduates. The Committee has also published a number of treatises, including a review of the periods of 'apprenticeship' which follow the completion of a medical degree, namely the pre-registration year and the year spent as a senior house officer.

The Fitness to Practise Procedures

15.21 The statutory basis of the FTP procedures is to be found in Part V of the 1983 Act. In the past, there have been three separate types of FTP procedure:

- the conduct procedures, which were the successors of the original disciplinary procedures of the GMC
- the health procedures, introduced by the Medical Act 1978, following the recommendations of the Merrison Committee. They came into operation in 1980 and were designed to deal with doctors whose fitness to practise was impaired by ill health
- the performance procedures, which came into operation in July 1997, and were designed to deal with doctors whose professional performance was found to be seriously deficient.

15.22 Throughout this Report, I shall refer to those procedures as the 'old' FTP procedures and will use the past tense to describe them. I shall describe the FTP procedures which have recently been introduced as the 'new' procedures and will refer to them in the future tense.

Present Structure

15.23 I have already explained that the GMC comprises 35 members, of whom 21 are registered medical practitioners and 14 are non-medical or lay members. The President, who is both leader and figurehead, is elected by the members for a period not exceeding seven years and is always an eminent member of the medical profession. The present incumbent is Professor Sir Graeme Catto, a distinguished consultant physician whose current appointments include Dean of Guy's, King's College and St Thomas' Hospitals Medical and Dental School, Vice-Principal, King's College London, and Professor of Medicine and Pro-Vice-Chancellor, University of London.

15.24 The 19 elected medical members are chosen by several different geographical 'constituencies' of doctors. Two medical members are appointed by the universities with medical schools and the medical Royal Colleges. The lay members, nominated by the Privy Council, are drawn from a variety of backgrounds. During the hearings, Leading Counsel for the Tameside Families Support Group (TFSG) drew attention to the fact that a significant number of lay members had a professional background in NHS management or administration. It was suggested that they were not really 'lay' people who could represent and safeguard the interests of the general public and of patients in particular. As a result of their professional backgrounds, they would be steeped in the culture of the medical profession and of NHS management. The GMC, in reply, suggested that it was appropriate for some lay members to have a background in health administration; this gave them an understanding of the quite complex structures of the NHS which was invaluable to them in their GMC role. In any event, said the GMC, the lay members were all extremely independent, whatever their background, and were very conscious of their duty to safeguard the interests of patients and the public.

15.25 I do not feel able to express any concluded view on this interesting difference of opinion. I see the advantage of having a knowledge of existing NHS procedures. Such knowledge will be very useful to a GMC member. The knowledge can be acquired, but that takes time. It also appears to me, from the evidence I have heard from and about lay members, that some of them are very independent in their thinking, notwithstanding their healthcare background. Dr Arun Midha, who has been a member of the GMC since November 2000 and was a lay screener from July 2001 until 2004, is a case in point. Dr Midha is not a medical doctor; his academic qualifications lie in the fields of social studies and business administration. He is Associate Director (Business and Planning) of the School of Postgraduate Medical and Dental Education, University of Wales College of Medicine. Before taking up that role, he held management and advisory positions with Health Promotion Wales and the Welsh Combined Centres for Public Health (Division of Public Health). Between May 1994 and January 2002, he was Programme Manager for the public health medicine training scheme in Wales. In the past, he has been a non-executive director of an ambulance trust and the lay chair of the NHS complaints panel in Wales. Although he is not medically qualified, therefore, it can be seen that Dr Midha has a background in the field of health care. Yet it was apparent from his decisions in the FTP procedures that he applied his mind in a completely independent way. On the other hand, I can understand the concerns expressed by the TFSG. Even if the lay members who have worked mainly in NHS management are in fact independent, their backgrounds may

create the impression that they are 'members of the same club' as the doctors. They may not bring a fresh eye to their scrutiny of GMC practices and procedures. It is vital that lay members should be people of an independent mind, able and determined to safeguard the interests of the public, including patients. I think that lay members should come from a range of different backgrounds. It may be that, in the past, the mix has been rather too heavily weighted towards the NHS professionals. I think that the GMC recognised the force of the points made by the TFSG and I hope that in future it will be possible to ensure that there is an appropriate mix of backgrounds among the lay members.

15.26 The Council meets about six times a year to discuss and decide major issues of policy. However, much of the work of policy development is carried out by committees or by working groups formed by those committees. I have already mentioned the Education Committee and the Standards Committee. These committees are composed mainly of GMC members, although some also have co-opted members. There are other committees whose functions range over fitness to practise, registration, finance and resources, audit and race, equality and diversity. There is also a 'Patient and Public Reference Group', comprising members of the GMC and others, who represent the interests of patients and consumers. For example, the Patients Association, the Consumers' Association (now known as Which?) and the Patients Forum are represented on it. The object of this Group is to allow continuing consultation between the GMC and patient groups on policy issues.

15.27 A considerable body of administrative staff supports the day-to-day work of the GMC. At the head is the Chief Executive and Registrar. The present incumbent of this post is Mr Finlay Scott. Below him are the Directors in charge of four directorates, dealing with fitness to practise, registration and education, corporate affairs and policy, and resources.

15.28 The Fitness to Practise Directorate is divided into a number of Sections, each dealing with a different aspect of FTP work and headed by a senior member of staff. These senior staff are not medically qualified; they usually have a background in administration – many of them in the Civil Service or quasi-governmental bodies. The handling of the thousands of individual cases reported to the GMC every year is undertaken by teams of caseworkers under the leadership and supervision of casework managers. Again, these members of staff do not usually have any medical qualifications. Most are graduates. In addition, there are secretarial and junior administrative staff.

15.29 In the past, important aspects of the preliminary work in the processing of an individual case were undertaken by medical or lay members of the Council. In the conduct procedures, for example, complaints of misconduct were referred by office staff to a 'medical screener' (a medically qualified member of the Council), who would decide whether or not the complaint should proceed to the next stage of the procedures. This was a sifting process. If the medical screener decided that the case ought not to proceed to the next stage, it would be closed, provided that a 'lay screener' agreed. In health cases, a 'health screener', a medical member of the Council (usually one who practised in psychiatry), was responsible for the supervision of a doctor who was subject to restrictions on his/her practice. In the performance procedures, a medical member of the GMC was appointed as a case co-ordinator. He or she would take important preliminary decisions,

which might include the drafting of a statement of requirements for re-education or remediation that the doctor might agree to undertake.

15.30 In future, under the new FTP procedures, it is likely that individual medical members of the GMC will not generally be responsible for any of the preliminary stages of the FTP procedures, as they have been in the past. Insofar as sifting functions require medical expertise, they will be undertaken by medically qualified members of staff, to be known as case examiners. Members of the GMC will be mainly concerned with issues of policy and governance. They will carry much less responsibility than before for decisions on individual cases.

15.31 In the past, five committees were responsible for deciding cases brought under the three types of FTP procedures. These were the Preliminary Proceedings Committee (PPC) and the Professional Conduct Committee (PCC) (conduct procedures), the Health Committee (HC) (health procedures), and the Assessment Referral Committee and the Committee on Professional Performance (CPP) (performance procedures). In addition, the Interim Orders Committee, created in 2000, had the task of deciding whether it was necessary to suspend a doctor's registration or to impose conditions on his/her registration pending a final decision on his/her case.

15.32 Panels of the various FTP committees traditionally comprised only members of the appropriate committee; for example, a panel of the HC would comprise sufficient members of that Committee to make a quorum. However, the number of FTP cases increased and it became necessary for multiple panels of FTP committees to sit simultaneously in order to reduce the long delays which were occurring before cases were heard. In order to make this possible, in 2000, the GMC sought and obtained the power to co-opt non-GMC members to sit on its FTP committees. The persons co-opted were known first as 'adjudicators', then as 'associates'. A large number of 'associates' (both medical and lay) were recruited to sit on FTP committee panels. When the number of GMC members was reduced in 2003, many retiring members were appointed as associates. By mid-2004, GMC members were no longer sitting on panels save in exceptional circumstances; instead, panels were composed entirely of associates. In future, under the new procedures, GMC members will be ineligible to sit on FTP panels, although they will be eligible to sit on panels of the new Investigation Committee. Whether they will, in fact, do so is as yet uncertain. All other panels will be composed of non-GMC members who have undergone training and assessment.

The 'Old' Fitness to Practise Procedures in Outline

15.33 The 'old' FTP procedures were governed by a range of statutory and internal, non-statutory provisions. The primary legislation was contained in Part V of the 1983 Act. However, each set of procedures had its own set of statutory Rules. In the past, the GMC had difficulty in obtaining amendments to the Rules or securing the passage of new secondary legislation. However, the provisions of section 60 of the Health Act 1999 enabled the GMC to secure much more speedy amendment of the Medical Act and the introduction of secondary legislation. Section 60 enabled the Department of Health to make certain amendments to primary legislation, including the 1983 Act, by Order in

Council. Such an Order is subject to affirmative resolution in both Houses of Parliament. The making of regulations and rules under the 1983 Act in relation to FTP procedures and revalidation is a matter for the GMC itself, but they have to be approved by Order of the Privy Council. The GMC also has a set of internal Standing Orders, comprising procedures that have been approved by the full Council. Some of these dealt with aspects of the FTP procedures. In addition, there are internal processes and guidance governing the way in which the GMC handles individual cases. It is not clear to me to what extent these internal processes and guidance have been expressly approved by the full Council. They may be approved by the Fitness to Practise Committee or may possibly be made under powers delegated to the Chief Executive.

15.34 As I have already explained, the three separate FTP procedures were introduced at different times and to fulfil different perceived needs. Some form of disciplinary procedure to deal with misconduct has existed for as long as the GMC itself, although many changes have been made over the years. For many years, the conduct procedures dealt with doctors who had been convicted of criminal offences and with those who were alleged to be guilty of serious professional misconduct (SPM). The health procedures came into effect in 1980 to meet the need to protect the public against doctors who were unfit to practise on account of ill health, while at the same time treating such doctors in a non-punitive and supportive way so as to help them to recover and to be rehabilitated into full practice. The performance procedures were introduced in 1997 and were intended to give the GMC the power to deal with doctors whose standard of professional performance was seriously deficient but whose poor performance could not be categorised as SPM.

15.35 The concept of SPM has given rise to considerable difficulty in interpretation. In Chapter 17, I shall discuss the meaning of SPM and the various attempts that were made over the years to define it. For the moment, suffice it to say that a wide variety of different forms of misbehaviour might amount to SPM. Often, these related to the doctor's dealings with his/her patients (for example, sexual misconduct), but behaviour which brought the medical profession into disrepute or which undermined public confidence might also amount to SPM even though it did not directly involve patients. For example, dishonesty in research might amount to SPM. In connection with clinical treatment, it had long been recognised that the wilful neglect of clinical responsibilities, such as a refusal to provide treatment when necessary, might amount to SPM. But negligent, as opposed to wilful, failures in connection with clinical treatment might also amount to SPM provided that the failure in question was sufficiently serious. It seemed to be assumed that members of the GMC would recognise a case of SPM when they came across it although, in fact, the evidence suggests that the issue of whether conduct amounted to SPM gave rise to frequent differences of opinion.

15.36 Similarly, there was no accepted definition of what was meant by seriously deficient performance (SDP). As with SPM, it seemed to be assumed that members would recognise it when they came across it. As with SPM, the lack of any authoritative definition gave rise to difficulties and differences of opinion. I shall discuss the meaning of SDP in Chapter 17.

15.37 All complaints, allegations and expressions of concern reaching the GMC were considered first by a case manager. He or she would follow detailed instructions when

considering whether the matter should be closed at that initial stage or whether it should advance into the FTP procedures. If s/he decided that the case was to proceed, s/he would send it either to a medical screener or, if it was clear that the case involved issues of ill health, directly to a health screener. The medical screener would consider whether the case raised any FTP issue, be it SPM, SDP or serious impairment of fitness to practise by reason of ill health. If s/he thought that it did, the case would be transferred to the appropriate Section. If s/he thought that no such issues were raised and that the case should be closed, a lay screener would examine the papers. If the lay screener agreed that the case should be closed, it would be. From that stage onwards, the procedures differed.

The Conduct Procedures

15.38 If either the medical or lay screener decided that a question of SPM had arisen, the case was handled in the Conduct Section and went to the PPC, which decided whether the case should proceed to a hearing before a panel of the PCC. Hearings before the PCC took place in public. If the PCC panel found the doctor guilty of SPM, it had the power to administer a reprimand, to impose conditions on the doctor's registration (such as practising under supervision or undertaking further training), to suspend the doctor from practice for up to a year or to erase his/her name from the medical register.

The Health Procedures

15.39 When a case was referred to the Health Section (by either a caseworker or a screener), it would be considered by a health screener. In the past, two medical members of the GMC acted as health screeners. From March 2004, two medically qualified case examiners were appointed to act as health screeners in place of the GMC members who had previously fulfilled this function. A very large proportion of all cases dealt with in the health procedures involved psychiatric problems of one sort or another. The health screener would write to the doctor inviting him/her to be examined by at least two medical examiners, usually psychiatrists. On receipt of the examination reports, the health screener would decide whether the doctor's fitness to practise appeared to be seriously impaired and, if so, s/he would devise a list of conditions (based on the recommendations contained in the examination reports) to which the doctor would be invited to agree. These might include restrictions on the circumstances of practice (such as not practising single-handed) and would always include a requirement that the doctor submit to medical supervision. If the doctor was continuing to practise, there would be a requirement that a professional supervisor should be appointed.

15.40 If the doctor agreed to the proposed conditions, the doctor was said to enter the 'voluntary' health procedures. He or she accepted the conditions and the health screener oversaw their operation, seeking periodic reports from the medical supervisor. If and when satisfied that it was appropriate to do so, the health screener might vary the conditions or terminate them, leaving the doctor free to practise. If the doctor did not accept the conditions thought appropriate by the health screener, or if the doctor refused to be examined at all, or was unfit to agree to conditions, the health screener might decide to

refer the case to the HC, which had the power to impose conditions upon the doctor's registration (in effect, the same kind of conditions as the health screener would have suggested) or to suspend him/her from practice for up to a year. The HC sat in private. It did not have the power to erase a doctor from the medical register although it could renew and extend either conditions or suspension. In certain circumstances, it could make a direction that a doctor's registration should be suspended indefinitely.

The Performance Procedures

15.41 The performance procedures were similar in operation to the health procedures in that they might be entered voluntarily or might operate by compulsion. When it appeared to a medical screener that a doctor's professional performance might have been seriously deficient and that it was appropriate to take action, s/he might invite the doctor to agree to an assessment of his/her performance by an Assessment Panel. If the doctor agreed, the case would be passed to the Performance Section, where arrangements for the assessment would be put in motion. A case co-ordinator would be appointed. In the past, two medically qualified members of the GMC acted as case co-ordinators. From March 2004, two medically qualified case examiners were appointed to act as case co-ordinators in place of the GMC members who had previously fulfilled this function.

15.42 The Assessment Panel would comprise one lay and two medically qualified assessors, one of whom practised in the same (or a similar) specialty as the doctor under scrutiny. One medical assessor would be appointed as the lead assessor. An assessment might take some months to arrange and complete. When the assessors had submitted their report, the case co-ordinator would decide whether the doctor's performance appeared to be seriously deficient. If so, s/he might devise a statement of requirements to which the doctor was invited to agree. The statement might require the doctor to undertake training in some aspects of his/her practice and might specify limitations (e.g. a requirement to practise under supervision) on his/her practice. If the doctor accepted the statement of requirements, s/he would enter the 'voluntary' performance procedures. The case co-ordinator would require periodic progress reports and, in due course, would arrange for a reassessment to be carried out. If all was satisfactory, the case co-ordinator might decide that the doctor should be free to practise without restriction. If the doctor failed to agree to or comply with the statement of requirements, or refused to co-operate in some other way, or if the case co-ordinator did not think that voluntary procedures were suitable, the case was referred to a panel of the CPP. The panel usually sat in private. If the panel decided that the doctor's performance had been seriously deficient, it might impose conditions on the doctor's registration or suspend the doctor from practice for up to a year. It had no power to erase a doctor's name from the medical register. Both conditions and suspension could be renewed and extended. In certain circumstances, a CPP panel could make a direction for indefinite suspension of a doctor's registration.

The 'Silo Effect'

15.43 Because the three different FTP procedures came into existence at different times, they operated separately and independently of each other. Although, in some limited

circumstances, it was possible for a doctor to be transferred from one set of procedures to another, a case could not be handled within more than one set of procedures at any one time. Thus, if a doctor presented with problems that included conduct, performance and health issues, a decision had to be taken as to where they were to be handled. The GMC referred to this as the 'silo effect'. The new FTP procedures have been designed to overcome this fundamental difficulty. It is intended that all cases will be investigated using flexible powers to obtain evidence of various kinds, including expert opinion about clinical practice, medical or psychiatric reports on the doctor's health, and performance assessment reports. If conduct issues arise, they will usually be determined by a FTP panel but the panel will also be able to consider any issues of performance or health which remain in dispute or which require the imposition of conditions or other sanction.

Criticism of the General Medical Council and the Movement for Reform

External Criticism

15.44 In his book, 'The Doctors' Tale'[1], Sir Donald Irvine (a member of the GMC from 1979 and its President from 1995 until 2002) described how the GMC came under increasing criticism from many quarters from the 1980s onwards. In his Reith Lectures of 1980, entitled 'Unmasking Medicine', Professor (now Sir) Ian Kennedy, currently Chairman of the Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission), was deeply critical of the GMC. He doubted that medical self-regulation would be adequate by the end of the twentieth century. He observed that, although the GMC had a duty to protect the public interest, it had no method of consulting with the public. He alleged that it dismissed far too many complaints about doctors without adequate investigation or public scrutiny. He considered that the GMC was not properly held to account by the Privy Council. He was concerned that the GMC's approach to its disciplinary procedures was governed by the amount of money it was prepared to spend on them. He suggested regular re-registration in place of the presumption that a doctor, once qualified, remained fit to practise unless and until it had been proved, on receipt of specific complaint, that s/he was unfit. He also suggested that there should be an inspectorate that would be able to look into all aspects of a doctor's professional practice. He observed that specific guidelines would be needed as to what constituted good practice.

15.45 Another voice of criticism was that of Mrs Jean Robinson, one-time Chairman of the Patients Association and a lay member of the GMC. In 1988, she published a monograph in which she was deeply critical of the opacity of the GMC procedures and of their failure to do anything to protect patients from the poor clinical performance of incompetent doctors. Professor Rudolf Klein, of the University of Bath, criticised the GMC's reactive approach to complaints of misconduct and its complete failure to tackle the problems of poor performance.

15.46 In 1989, the British Medical Journal published a series of articles by Mr Richard Smith, then an editorial assistant. These were severely critical of the GMC. It was said that the

[1] Irvine, Donald (2003) 'The Doctors' Tale'. Oxford: Radcliffe Medical Press.

GMC was too large and its membership too old and too conservative. It was too interested in internal issues and was not sufficiently concerned about issues of medical education and clinical incompetence. Also, it should have been (but was not) seen to be serving the public interest; instead, it complained when criticised in the media.

15.47 One might summarise those criticisms by saying that the GMC was 'doctor-centred'. It appeared to assume that all doctors were good, competent and conscientious until proved otherwise. It would deal with the profession's 'bad apples' for the sake of the profession. It would do so in its own way and did not welcome scrutiny. Its procedures were designed to be fair to doctors and to ensure that no doctor would lose his/her right to practise without very good cause. It did not focus on the reasonable expectations of the public and it did not see itself as having a duty to ensure that all members of the medical profession were willing and able to provide a proper professional service.

15.48 Since the time when this criticism was at its height, the GMC has made considerable efforts to change. The development of the performance procedures in the early 1990s, and the improvements in the health procedures, which I shall describe later, are examples of this. In 'The Doctors' Tale', Sir Donald Irvine described his election to the Presidency on a 'reforming ticket'. He won the election but explained that the road to reform was not always easy. To some extent, events were to push the GMC forward. The tragedies of the Shipman case, the events surrounding the failure of paediatric heart surgery at Bristol Royal Infirmary and the case of Rodney Ledward (a consultant gynaecologist, whose lack of skill had caused injury to many of his patients over a period of 15 years or so) were important agents of change in the late 1990s. However, even before then, an expression of concern about the possibility of racial bias within the GMC had led to a wide-ranging examination of the GMC's internal procedures and to many important procedural changes.

The Work of the Policy Studies Institute

15.49 In 1994, an analysis of the nature and outcome of cases considered by the PCC over a ten-year period was brought to the attention of the GMC. This analysis appeared to suggest that doctors from the ethnic minorities were more likely to be brought before the PCC than were white doctors. To its great credit, the GMC decided that these concerns must be fully investigated. The GMC instructed the Policy Studies Institute (PSI) to do the work and gave the PSI team full access to all the relevant material that was available.

15.50 Allegations of racial bias are completely outside the Inquiry's remit. However, allegations that the GMC is biased towards doctors are not. The Inquiry is aware that there is a public perception that the GMC often favours the doctor as opposed to the complainant in its decision-making processes. This is an allegation of bias in another form. The work of the PSI team was to shed a great deal of light upon the procedures of the GMC. Those procedures are of interest to the Inquiry. Only if the GMC's procedures were thorough, fair and transparent would it be possible to say whether there was bias against complainants and whether patients were being properly protected from the actions of doctors reported to the GMC for alleged misconduct or incompetence.

15.51 The purpose of the PSI study was, first, to look for evidence of racial bias in the existing GMC procedures and processes and, second, to consider whether any changes should be made to minimise the risk of racial bias in the future. The study was confined to the GMC's conduct procedures. The study team was led by Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster PSI. Initially, Professor Allen and her colleagues analysed complaints made to the GMC against doctors in the 12 month period to August 1994. A Report (the 1996 PSI Report), setting out their findings and recommendations for change, was presented to the Racial Equality Group of the GMC in November 1995 and published in 1996.

15.52 The PSI team had considerable difficulty in carrying out its work. It found that the GMC data was largely recorded by hand. There was no reliable log or database of past complaints. The way in which complaints were classified made it difficult to analyse their seriousness. Papers relating to past complaints were stored in the same files as enquiries, general correspondence and press cuttings. Papers relating to an individual doctor were not necessarily filed together. An analysis carried out by the PSI team cast doubt upon the accuracy of statistics previously produced by the GMC. As a consequence of these difficulties, the 1996 PSI Report made detailed recommendations about steps which should be taken to establish a reliable and accurate database of complaints. The Report also made many observations and recommendations about the GMC's procedures for handling complaints. I shall refer to some of these in the Chapters that follow.

15.53 On the issue of racial bias, Professor Allen and her colleagues reported that they found **'no evidence of any overt racial discrimination or bias in either the procedures or the processes relating to conduct'**. Nor did they find evidence of any form of overt racial discrimination or bias in any interview or informal encounter with GMC staff or members or in any written comment found on the GMC files. Nevertheless, the statistical analysis carried out by the PSI team clearly showed that doctors who had qualified overseas or who had a name which suggested that they belonged to an ethnic minority were more likely than those who had qualified in the UK or Ireland or who had an English or European name to be referred on through the FTP procedures, as opposed to having their case closed at an early stage. The major difference between the groups was found in the proportion of each group referred by the PPC for a hearing before the PCC. These differences could not be satisfactorily explained because of the opacity of the GMC processes.

15.54 The 1996 PSI Report made clear that the fact that there were differences in outcome between the two groups did not of itself mean that there was racial bias within the GMC. It might just have been that the complaints against overseas qualifiers and those from non-English/European countries were more serious than those against members of the other groups. However, the possibility of bias could not be ruled out. The main conclusion of the Report was that, unless all the GMC procedures for handling complaints against doctors were transparent and open, it would not be possible to demonstrate that there had been no bias. The Report recommended a number of steps that the GMC should take in order to make its procedures more open, transparent and consistent. I shall discuss those recommendations later in this Report.

15.55 In 1998, the GMC commissioned a follow-up study from the PSI, which resulted in a further Report. The aim of this follow-up study was to identify any factors which might explain

differences in the representation of overseas qualified doctors at the various stages of the GMC conduct procedures. Before beginning its follow-up study, the PSI team recommended some immediate changes to the GMC procedures. These were designed to streamline the screening process and to improve the transparency and consistency of decision-making. I shall describe these changes in Chapter 19. The PSI team carried out a quantitative analysis of complaints received by the GMC in the calendar years 1997, 1998 and 1999, and examined the results for evidence of racial bias. In addition, the study examined the screening process, including the effects of the changes to the process which had been introduced by the GMC on the advice of the PSI team. The study also examined the decision-making processes of the PPC.

15.56 By the time the follow-up study began, the GMC had made considerable progress in implementing the recommendations contained in the 1996 PSI Report. In particular, its data collection system had been computerised and the process of tracking complaints had been made much easier. However, the number of complaints received by the GMC annually had increased markedly and considerable delays were occurring in the processing of complaints. At this time, the GMC had a relatively small staff, many of whom had been employed for a long time. Skills had been passed on by personal contact and mentoring and the GMC had not at that stage developed systems which would enable it to enlarge its staff and train new personnel to deal with this increased workload.

15.57 The analysis performed by the PSI team showed that, in all three years studied, there was an unexplained discrepancy between the number of UK qualified doctors referred to the PCC by the PPC and the number of overseas qualified doctors so referred. For example, in 1999, of the cases referred to the PPC, the proportion of UK qualifiers sent by the PPC for hearing at the PCC was 33%, whereas the proportion of overseas qualifiers sent was 54%. Professor Allen and her colleagues could not account for that difference. They noted that, since the PPC did not keep a contemporaneous record of its deliberations and gave no reasons for its decisions, no firm conclusions could be reached. There were also significant, unexplained differences between UK and overseas qualifiers in the outcomes of cases heard by the PCC.

15.58 The 2000 PSI Report made a number of recommendations, which I shall discuss in later Chapters. For the moment, it suffices to say that the general thrust was that, in order to provide consistency and transparency in GMC decisions, there was an urgent need for the development of standards and criteria. In particular, there was a need for a clear definition and an agreed interpretation of SPM.

15.59 In 2002, Professor Allen and her colleagues were commissioned to carry out further work for the GMC. They conducted a preliminary analysis of the data relating to complaints received by the GMC in 1999, 2000 and 2001. Their findings were set out in a Paper. The analysis showed marked differences between the relative proportions of UK and overseas qualified doctors referred to the PPC by individual medical screeners. Some screeners referred equal proportions of UK qualifiers and overseas qualifiers, whereas other screeners referred three times as many overseas qualifiers as UK qualifiers. As the distribution of cases to the screeners was said to be random, it appeared that the screeners must be applying different standards. Again, the proportion of overseas

qualifiers referred by the PPC to the PCC was higher than that of the UK qualifiers. There were also continuing differences between UK qualifiers and overseas qualifiers in the outcomes of cases heard by the PCC. Once again, Professor Allen and her colleagues observed that it was possible that the complaints received about overseas qualifiers had been more serious than those about their UK counterparts. That would explain the disproportionate referral rates and the differences in outcomes. But, in the absence of objective criteria against which decisions could be measured, it was still impossible to demonstrate this.

15.60 Thus, in three studies, conducted over a period of nine years, the PSI found unexplained differences in the treatment by the GMC of overseas qualifiers as compared with UK qualifiers; the overseas qualifiers were more severely dealt with. This may or may not indicate that there is racial bias within the GMC. The importance of these findings, from the Inquiry's point of view, is that the procedures are lacking in transparency. It ought to be possible to refute a suggestion of bias if it can be demonstrated that decisions are taken according to objective criteria and by the consistent application of established standards. Professor Allen has repeatedly advised the GMC that it will be unable to refute the allegations of racial bias unless and until it develops objective standards and criteria. It seems to me to follow that, without such standards and criteria, the GMC will be unable to satisfy the public that it is complying with its duty to protect patients.

Recognition of the Need for Change

15.61 I have mentioned that a number of events occurred in the late 1990s (Bristol, Ledward, Shipman) which appeared to give rise to a collective public loss of confidence in the medical profession in general. I say 'collective' and 'in general' because it does not seem to me that there was any loss of confidence by individuals in the doctors who were treating them personally. Both Government and the GMC recognised the need for radical change. This has resulted in a programme of reform on three fronts. First, the constitution of the GMC has been changed; as I have already noted, the large unwieldy Council of 104 members has been reduced to one of 35 members and the proportion of lay members has been increased. Second, the GMC announced its intention to overhaul its FTP procedures. The new procedures have recently come into force. Third, the GMC intends to introduce, in 2005, a system of re-licensure to be known as revalidation. I shall discuss the proposals for the FTP procedures and revalidation in greater detail in later Chapters.

15.62 Other changes have very recently been made to the regulatory landscape. In 2004, the Healthcare Commission came into being, with responsibility for the supervision of the function of NHS bodies and private medicine. It is also responsible for the 'second stage' of patients' complaints about NHS doctors and services. Although this body will not have any direct involvement in the regulation of doctors by the GMC, it could well have an indirect effect. For example, it might refer to the GMC cases it has investigated through its involvement with the complaints procedures and where it has found cause for concern about the fitness to practise of a doctor.

15.63 Of more direct effect on the regulatory landscape was the creation in 2003 of the Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare

Regulatory Excellence (CRHP/CHRE)). This body has an overarching responsibility for the regulators of healthcare professionals, including, of course, the GMC. The powers of the CRHP/CHRE include the power to investigate and report on the performance by regulators of their functions, and to make recommendations for change. It can also give directions requiring a regulatory body to make specified rules if it considers that it would be desirable to do so for the protection of members of the public. Section 28 of the National Health Service Reform and Health Care Professions Act 2002 also gives the Secretary of State for Health powers to make regulations enabling the CRHP/CHRE to investigate complaints from individuals about the way in which a regulatory body has exercised any of its functions. The CRHP/CHRE also has the power to appeal against certain decisions of regulatory bodies that appear to be unduly lenient where it would be desirable, for the protection of the public, for the CRHP/CHRE to take action. Appeals by the CRHP/CHRE lie to the High Court. This is a wholly new concept in the field of professional regulation. Whereas, previously, only an individual aggrieved at a decision of the GMC had had the right to challenge that decision, an appeal now lies, in effect, on behalf of the public interest.

From the Horse's Mouth

15.64 In the following Chapters, I shall examine the GMC's old FTP procedures in some detail. I shall examine not only how those procedures were supposed to work but also how they operated in practice. I shall also examine in some detail the GMC's proposals for the future, in particular the new FTP procedures and revalidation. As will soon become apparent, I will be critical of many aspects of the GMC's work in the past.

15.65 The GMC's stance at the Inquiry was not that it has, at all times, been perfect. Very realistically, those representing the GMC recognised that there has been much to criticise. On the day on which the Inquiry turned to examine the work of the GMC, its Leading Counsel, Mr Roger Henderson QC, made frank admissions in relation to many of the shortcomings which had become evident in the course of the Inquiry's investigations. He accepted that the GMC procedures had failed in many respects to meet the reasonable expectations of the public and patients. His message to the Inquiry was that these deficiencies had been recognised and addressed. He spoke of the paramount duty of the GMC to safeguard patients' interests, while having due regard for the interests of doctors.

15.66 I welcomed Mr Henderson's admissions, which were clearly made with the authority of the GMC at the highest level. I recognise that they were made in the hope that the Inquiry's criticisms might be muted or even silenced in the light of the GMC's recognition of its past faults. They were nonetheless welcome for that. They are important and I propose to summarise them.

15.67 First, in respect of operational matters, Mr Henderson admitted that there had been unacceptable delay in dealing with complaints and concerns about doctors. He accepted that the GMC had failed adequately to investigate complaints and had failed to follow up complaints that had been referred to other bodies for investigation. He accepted that cases had been closed which should not have been closed.

15.68 Second, in respect of the quality of decision-making, Mr Henderson accepted that there had been a lack of consistency and that the quality of decisions had been variable. He accepted that the approach had been 'idiosyncratic rather than systematic' and the resulting disparity between the outcomes of cases 'unacceptable'. Mr Henderson attributed the lack of consistency, in part, to the 'absence of satisfactorily planned and structured training'. He said:

> **'It may have been thought invidious for elected Council members to require training whether as screeners, members of the PPC or of the PCC. Such an old-fashioned approach is long outmoded and is recognised as being wholly out of keeping with the needs of today and tomorrow. The philosophy of voluntary, well-meaning, judgmental concern can be no substitute for suitable training of suitably qualified people guided by systematised, coherent and carefully planned procedures enshrined in clear text on the subject of appropriate supervision and audit.'**

15.69 Mr Henderson drew attention, very properly, to the attempts that had been made to provide training and guidance for those making decisions but accepted that they had not been sufficient. He said that the GMC now recognised the need for structured training for decision-makers. While I accept and agree with all that Mr Henderson said about training and guidance, I observe that he did not mention the need for clear standards and criteria as the basis for decisions.

15.70 Mr Henderson suggested that another cause of inconsistency and poor quality in decision-making was the fact that it had not in the past been the practice for GMC panels or committees to give reasons for their decisions. He said that 'the giving of reasons is salutary'. He said (and I agree) that the discipline of having to give reasons improves the decision-making process. He pointed out, in defence of the GMC's failure to give reasons in the past, that the Privy Council had, until recently, approved its practice. That had now changed, although Mr Henderson conceded that, even in recent times, the reasons given were not always what they should be.

15.71 So far as screening decisions were concerned, Mr Henderson admitted that there had been disparity between outcomes. He attributed this to a failure by the GMC to appreciate the true nature of the screening process until advised about it by Mr Justice Lightman in the case of R v General Medical Council ex parte Toth[2] in 2000. Until then, Mr Henderson said, screeners had wished to bring their professional judgement to bear on cases in a way that was, in fact, inappropriate. He accepted that too many cases had been 'screened out'. When referring to some of the cases which the Inquiry had examined and had found to contain inconsistent decisions, he concluded:

> **'With the benefit of proper audit and consistent training, there should have been a consistent set of results leading to more Committee decisions comprised of persons who, in turn, would, by training and documentation, have avoided some of the problems which some of those chosen cases reveal.'**

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[2] [2000] 1 WLR 2209.

15.72 Mr Henderson also acknowledged that there had been insufficient audit of GMC decisions. Indeed, he accepted that such audit of decisions as had occurred (and that had occurred only in recent years) had been 'in character more enumerative than qualitative'. In other words, audit had looked at how many cases had been dealt with, not whether they had been properly decided. He agreed that that was not good enough and that proper audit was now required. The lack of transparency in GMC decisions was now, he said, being addressed.

15.73 Mr Henderson's message to the Inquiry was that the failings of the past have been recognised and addressed. The new FTP procedures would resolve not only the difficulties caused by the 'silo effect' of the separate procedures but would also ensure that cases were properly investigated and eventually resolved by decisions taken by persons who were qualified and trained for the task.

Conclusions

15.74 Since Stage Four of the Inquiry began, there has been some speculation in the newspapers, particularly in the medical press, that the Shipman Inquiry might 'bring down' the GMC. It was suggested that I might recommend the 'abolition' of the GMC. Such speculation was ill informed. Before Stage Four began, I set out the issues that the Inquiry would examine. The future existence of the GMC was not among them. The Inquiry published a Consultation Paper in October 2003, in which the views of respondents were sought on a wide range of issues. Those issues did not include the 'abolition' of the GMC or the ending of self-regulation for the medical profession. It is unthinkable that I would make such wide-ranging recommendations without giving proper notice.

15.75 The Inquiry's Terms of Reference are wide and certainly require me to examine the GMC's performance of its FTP functions. They are, I think, wide enough to permit me – indeed to require me – to consider whether those functions should be carried out in a different way or even by a different body. They are wide enough, I think, to permit me to suggest that the GMC should organise itself in a different way, so that it might better fulfil its primary duty to protect patients. What they do not permit, in my view, is any consideration of whether the GMC should continue to exist or whether self-regulation of doctors should be ended. In my view, if those matters are to be considered, the task must be undertaken by a body charged with examination of all the GMC's functions. This Inquiry has focussed on the FTP procedures and on revalidation. The GMC has other important functions, which this Inquiry has not touched upon.

15.76 I have just referred to the 'self-regulation' of the medical profession. Throughout its evidence and in its submissions to the Inquiry, the GMC has been at pains to point out that the regulation of the profession is now a complex operation in which many other bodies play a part. These include the NHS bodies which employ or contract with doctors, the Healthcare Commission which has wide-ranging responsibility for the audit and inspection of healthcare services and the CRHP/CHRE. The GMC says, and I accept, that it must work in partnership with those other bodies. The GMC is dependent upon other bodies (and patients and other healthcare professionals) reporting to it their complaints

and concerns about doctors. Nonetheless, the GMC plays the key role as the keeper of the register. The GMC decides who can practise as a doctor and who cannot.

15.77 In recent years, the GMC has been the subject of much public criticism, most of it stemming from the way in which it has dealt with or failed to deal with doctors who have been guilty of some form of misconduct. The FTP procedures are the public face of the GMC and the most likely point of contact with the GMC for ordinary members of the public. The fact is that the public has come to regard the GMC with suspicion and distrust because it perceives that the GMC acts, not in the interests of patients, but in the interests of doctors. Indeed, many members of the public have the impression that the GMC is a representative body, akin to a trade union. Paradoxically, the GMC also comes in for criticism from the profession, where the perception is that the GMC is unfair to doctors and too hard on them. These issues of 'ethos and attitudes' go to the heart of whether the GMC is in fact acting, as it claims to act, in the interests of patient protection. Consideration of these issues has required a careful and detailed review of what the GMC does and how it operates in practice.

15.78 Examination of the ethos and attitudes of the GMC has been a vital part of the Inquiry's work. However, practical matters are also important. A body cannot work effectively for the protection of patients if its procedures and practices are inefficient. One of the criticisms levelled against the GMC is that there has at times been unacceptable delay in dealing with complaints and in bringing doctors before a disciplinary committee. Mr Scott and Mr Antony Townsend, who was Head of the Conduct Section from 1993 to 1995, accepted that until the mid-1990s, the GMC's administrative systems were old-fashioned and inadequate. Much has been done to improve them and to reduce the delay that previously occurred. The GMC now operates according to service standards.

15.79 Besides examining attitudes and procedures, the Inquiry has had to consider the FTP procedures themselves and whether they are effective as a means of protecting patients from doctors who misbehave or fail to practise at an acceptable level. Much of the Inquiry's investigation was designed to discover that. Before that investigation had even begun, the GMC had recognised that its current procedures were not effective and that they must be changed. As the Inquiry was doing its work, the GMC was developing its new FTP procedures. They have now been introduced.

15.80 In its evidence and submissions to the Inquiry, the GMC sought to assure the Inquiry (and indeed the public) that the new FTP procedures will be very different from the old. I hope that they will. But, in seeking to make recommendations for the better protection of patients in the future, I must form a view as to whether the GMC will, in the event, be willing and able to ensure that all is indeed different. It is axiomatic that the best indicator of future attitude and performance is past attitude and performance. Changes of practice and performance are, of course, possible, as the GMC has already demonstrated. Changes of attitude are more difficult to bring about. In the following Chapters, I shall set out in detail how the FTP procedures have worked in the past and the conclusions I have reached about the ethos of the GMC in the past. I shall also consider the evidence relating to the way in which the new procedures have been developed and are likely to operate in the future. I shall consider whether that evidence demonstrates a change of ethos within the

GMC. Finally I shall consider what steps or further steps should be taken by the GMC to ensure that patients and the public receive the protection they deserve from doctors who, for one reason or another, are not practising as they should.