CHAPTER TWENTY FOUR

The General Medical Council's Performance Procedures

Introduction

24.1 In July 1997, the General Medical Council (GMC) introduced its performance procedures, which enabled it to take disciplinary action in respect of doctors whose professional performance was seriously deficient. In this Chapter, I propose to examine the origin of these procedures, the way in which they were brought into operation and the way in which they worked until recently. I shall consider a number of problems which arose in their operation. Finally, I shall consider a few cases which the Inquiry has examined. As I shall explain, these procedures were not brought into effect until just over a year before Shipman was arrested and, in effect, ceased practice. None of the reports that the GMC received about Shipman would have been likely to result in a referral into the performance procedures, even if they had existed at the time. The procedures are, however, relevant to the Inquiry's remit for two reasons. First, they formed an important part of the GMC's armoury in protecting patients against doctors who might cause them harm. Second, the new fitness to practise (FTP) procedures will underpin the GMC's revalidation of doctors. The way in which issues of poor performance are handled within the new FTP procedures is plainly important in that context, and the only guide currently available as to how performance issues will be handled in future is how they have been handled in the past.

The History

24.2 In the 1980s, there was increasing concern about the competence of some doctors and about the inability (or, as some saw it, the unwillingness) of the GMC to deal with issues of competence by means of its conduct procedures. Outside the GMC, the case of Alfie Winn (see Chapter 17) in 1982 had resulted in attempts by Mr Nigel Spearing MP to introduce a Private Member's Bill establishing an offence of 'professional misconduct', with a threshold lower than that for serious professional misconduct (SPM). The GMC was successful in opposing those attempts and the Bill failed. However, even within the GMC, some members who sat on the Professional Conduct Committee (PCC) were becoming increasingly concerned about cases where, although SPM was not proved, there was nevertheless evidence of poor practice. The GMC was powerless to act in such a case.

24.3 Although Mr Spearing's Bill failed, his attempts led directly to the establishment, in 1987, of a GMC working party, which was charged with the task of considering the need for competence procedures, as an adjunct to the existing conduct and health procedures of the GMC. The working party reported in 1989. It recommended that the GMC should give consideration to the establishment of competence procedures and that proposals for such procedures should be formulated as a basis for discussion with the profession and with other bodies. A year later, a decision was taken to establish a further working party to **'consider arrangements for the identification and handling of serious deficiency in a doctor's professional performance and to make recommendations'**.

24.4 Sir Donald Irvine, who was a member of the GMC in 1979 and its President from 1995 to 2002, described in his book, 'The Doctors' Tale'[1], the unwillingness on the part of some within the GMC to tackle the problems of incompetence and poor performance. He spoke of the pressure being put on the GMC by the Government of the time to **'grip the question of the incompetent doctor and grip it soon'**. If the GMC did not do so, it was told, the Government itself would act through Parliament. Sir Donald concluded this part of the history:

> **'... the received wisdom today is that the GMC's decision to go with what was to become the performance procedures in the 1990s was as a result of strongly pro-active action. It was not. Such action had to be dragged out of the Council, as many of the medical members glanced over their shoulders, perhaps quite understandably, at what their colleagues might say in other places, such as the craft committees of the BMA** (*British Medical Association*)**.'**

24.5 In May 1992, the working party, which had been set up two years before under the Chairmanship of the President of the GMC, Sir Robert (later Lord) Kilpatrick, reported. It recommended the establishment of performance procedures modelled on the relatively new health procedures. The performance procedures were designed to deal with cases where a doctor's behaviour or actions seemed to suggest a pattern of seriously deficient performance (SDP) that could not be dealt with effectively under the existing conduct and health procedures. A novel element in the performance procedures was to be the performance assessment, which would be designed to identify gaps in a doctor's knowledge and skills and to assess whether these were capable of remediation. At that time, it was envisaged that most doctors entering the performance procedures would be dealt with by means of voluntary procedures (as in the health procedures) and would eventually return to unrestricted practice after a period of remedial action. In the event that a doctor failed to co-operate, or that his/her performance failed to improve after remedial action, a FTP committee of the GMC (subsequently titled the Committee on Professional Performance (CPP)) would be able – as a last resort – to suspend or impose conditions on the doctor's registration.

24.6 The proposals of the working party, which were adopted by the GMC, met with considerable opposition within the profession. There was anxiety about the prospect of testing doctors' clinical knowledge or skills. There was a suggestion from those representing hospital doctors that the performance procedures should not apply to them, since any problems with performance could be dealt with by their employers, in conjunction with the BMA or the relevant medical Royal College. Eventually, however, there was a general acceptance within the profession that the performance procedures were necessary and must apply to all doctors.

24.7 Primary legislation was required for the establishment of the procedures. The necessary Parliamentary time was found in December 1995 and the Medical (Professional Performance) Act 1995 (the 1995 Act) was passed, making the necessary amendments to the Medical Act 1983. In the meantime, work had begun on developing the instruments

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

to be used in the performance assessments. Following the passage of the 1995 Act, a further 18 months passed before the performance procedures eventually came into operation on 1st July 1997.

24.8 Sir Donald told the Inquiry that he had believed that the performance procedures would close a 'gaping hole' in the GMC's procedures, a hole which he had observed 'time and time again' when sitting on the PCC. He said:

> **'... you would find that facts could not be proved, or you could not arrive at a decision about serious professional misconduct, but you knew perfectly well from what you had seen in the evidence, the records you may have looked at and so on ... that the doctor just should not be practising'**.

He said that, as a general practitioner (GP), he knew about the 'sizeable volume' of people who either should 'have some attention given' to their practice or should not be practising at all. He had seen the introduction of the procedures as a way of strengthening local processes and procedures. He had had 'high expectations' of them.

The Distinction between 'Performance' and 'Competence'

24.9 I have described how, in the first instance, the suggestion was that the GMC should establish 'competence procedures'. Within a short time, however, the emphasis had changed from 'competence' to 'professional performance' and the procedures, when eventually they came into effect, were concerned with performance, rather than competence.

24.10 'Competence' describes knowledge and skills, i.e. what the doctor 'can do'. 'Performance' describes what the doctor does within actual practice, i.e. what s/he 'does do'. A doctor who does not possess the requisite knowledge and skills can never perform well. However, a doctor may be competent (i.e. s/he may possess the requisite knowledge and skills) but, nevertheless, his/her attitude and behaviour may be such that his/her performance is – at least on occasion – deficient. Professor Dame Lesley Southgate, Professor of Primary Care and Medical Education, University College London, explained at an Inquiry seminar that, sometimes, doctors who 'can do' have a problem about whether they 'will do'. She said that problems of attitude, which sometimes stem from an arrogant personality, can be very difficult to cure. The performance procedures were designed to deal with these wider problems, as well as with incompetence.

24.11 The change of focus from competence to performance had implications for the collection of the evidence necessary to prove SDP. A doctor's competence can be assessed by testing his/her current knowledge and by observing his/her current clinical skills. If the doctor is still in practice, his/her current performance can be assessed by observing him/her consulting with or treating patients and by reviewing and discussing medical records in current cases. However, if a doctor is for some reason no longer practising (for example, if s/he has been suspended) or if s/he is working in a specialty different from that in which s/he was working at the time of the original complaint against him/her, the only available measure of his/her 'performance' is not what s/he 'does' but what s/he 'has done'.

Local Mechanisms for Dealing with Poor Performance

24.12 At the time when the GMC's performance procedures came into operation, local NHS bodies – in particular, primary care organisations (PCOs) – had very limited mechanisms for dealing with poor performance. If a PCO had concerns about a GP's performance, it might seek the co-operation of the local medical committee (LMC) in invoking the informal 'Three Wise Men' procedure and try to resolve the problem in that way. If a patient complained about a 'performance' issue, that might be the subject of an independent review panel (IRP) hearing. If a PCO believed that a GP had breached his/her terms of service, there was the possibility of disciplinary action although, after 1996, such action became very rare. In any event, both IRP hearings and disciplinary proceedings were primarily designed to deal with single incidents giving rise to complaints, rather than with repeated incidents which might suggest a pattern of poor performance.

24.13 Following the introduction of the GMC's performance procedures, NHS organisations were encouraged, by the Department of Health, to set up their own procedures for dealing with poorly performing doctors. One reason for this was that the GMC's procedures were designed to deal only with doctors whose performance was 'seriously' deficient. It was recognised from the first that there would be doctors performing at an unacceptable standard who would not reach the GMC threshold, but in respect of whom it was necessary to take some action to protect patients. In Chapter 5, I described the local procedures that have been developed by PCOs since 1998. The process of development is continuing.

24.14 In order to assist NHS organisations to deal with problems of poor performance, in April 2001, the National Clinical Assessment Authority (NCAA) was established. It provides a support and advice service, and also carries out performance assessments in a limited number of cases where these are deemed necessary. These assessments are aimed at establishing whether a doctor is fit to work in the setting in which s/he is currently working. The assessment may result in a recommendation that the doctor should work in a different setting. It may recommend some form of remedial action. The NCAA is not a regulatory body and cannot itself take disciplinary action or impose sanctions. However, it can refer a doctor to the GMC, if, for example, serious concerns arise during an assessment, particularly if they affect patient safety. It may also advise the doctor's employer or PCO as to whether a referral by them to the GMC is appropriate.

The Development of the Instruments for Performance Assessment by the General Medical Council

24.15 When the GMC decided that it wished to introduce performance procedures, it was recognised that it would be necessary to devise some form of objective assessment of a doctor's performance. Such assessment would have to be fair and decisions based upon it would have to stand up to legal challenge. In 1994, the then President of the GMC (Lord Kilpatrick) invited Dame Lesley Southgate, who was then Chief Examiner of the Royal College of General Practitioners (RCGP), to lead a group which would be responsible for the development of a method and a set of instruments for the assessment of performance. No such methods or instruments had at that time been developed in any other part of the

world. Dame Lesley assembled a team, drawn mainly from the medical Royal Colleges, and, over a period of three years, produced the method and instruments which were to form the basis of the GMC performance procedures. When published later, this work gained worldwide recognition. The method and instruments of assessment have been described as 'state of the art' and 'the leading edge of direct assessment of performance'. They provide for a very thorough assessment and are, as an almost inevitable consequence, expensive to undertake.

24.16 As I shall later explain in greater detail, the assessment of performance falls into two phases. Phase I comprises a review of the doctor's performance at his/her place of work undertaken by a team of assessors. If, at the end of Phase I, the team is not satisfied with the doctor's performance, the doctor will undergo Phase II, which comprises a series of objective tests.

Witnesses

24.17 The Inquiry heard oral evidence about the performance procedures from Mr Alan Howes (Head of the Performance Section from 1995 until April 2001), Mr Neil Marshall (Head of the Performance Section from April 2001 until March 2002) and Miss Jackie Smith (a casework manager in the Performance Section from November 2001 until April 2002 and thereafter Head of the Performance Section). Sir Donald Irvine (President of the GMC at the time of the introduction of the performance procedures), Professor Sir Graeme Catto (the current President), Mr Finlay Scott (Chief Executive of the GMC since 1994) and Dr Krishna Korlipara (a member of the GMC and a medical screener since 1998) also gave relevant evidence. Professor David Hatch, Chairman of the CPP, provided a witness statement.

The Legislative Framework

24.18 The 1995 Act added a new section 36A to the Medical Act 1983. Section 36A provided:

> **'... (1) Where the standard of professional performance of a fully registered person is found by the Committee on Professional Performance to have been seriously deficient, the Committee shall direct –**
>
> **(a) that his registration in the register shall be suspended, (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction; or**
>
> **(b) that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with the requirements so specified.'**

24.19 It should be noted that the power to take action arose when the CPP found that the doctor's performance had been (i.e. in the past) seriously deficient. The significance of these words was not to become apparent until a challenge to the CPP's powers was raised in

the case of Krippendorf v General Medical Council[2], to which I shall refer later. It should be noted that no power was given to the CPP to direct that a doctor's name should be erased from the register. However, the CPP had the power, at the expiration of a period of suspension, to direct that the period of suspension should be extended for up to 12 months and, when a doctor had already been suspended for at least two years, the CPP then had the power to direct indefinite suspension. I shall discuss these sanctions in greater detail later in this Chapter.

24.20 It is important to note that the performance procedures applied only to a doctor's performance after 1st July 1997, the date on which the 1995 Act came into force. Evidence of poor performance prior to that date could not be used to support a complaint of poor performance against the doctor. The GMC decided (apparently on legal advice) that it was not possible, immediately after the introduction of the performance procedures, to deal with doctors about whom there had been longstanding concerns. Instead, it was necessary to wait until a body of evidence had been accumulated after 1st July 1997 to support the contention that the doctor's performance had been seriously deficient. This meant that the GMC's performance procedures got off to a slow start. The legal advice received may have been correct, although I cannot see any statutory prohibition on the consideration of evidence of poor performance occurring before the commencement of the power to impose sanctions for SDP. I would have thought that the opposite view would, at least, have been arguable. Given that the purpose of the new procedures was the protection of patients, it was perhaps unnecessarily conservative for the GMC to take so narrow a view of the commencement provisions. In any event, it was expected that many doctors whose performance was thought to be seriously deficient would agree to enter into voluntary undertakings. Such doctors would be unlikely to mount a legal challenge to the GMC's powers.

The Process for Dealing with Complaints about Performance

24.21 The General Medical Council (Professional Performance) Rules Order of Council 1997 (the 1997 Performance Rules) came into force in July 1997. They set out the process to be followed when a complaint was made or information was received (I shall use the term 'complaint' to describe both) about a doctor's performance. Broadly, the process consisted of the following stages:

- staff in the Screening Section considered the complaint
- the complaint was screened by a medical screener
- if the case proceeded beyond screening, the doctor was invited to undergo a performance assessment
- if the doctor did not agree to a performance assessment, the Assessment Referral Committee (ARC) would consider the case and decide whether a performance assessment was necessary

[2] [2001] 1 WLR 1054.

- if the doctor agreed to a performance assessment, or if the ARC directed an assessment, a case co-ordinator would be appointed
- the case co-ordinator would appoint an assessment team, of which one member was the lead assessor
- the assessment was carried out and a report was written. The lead assessor was responsible for this
- the performance assessment report was considered by the case co-ordinator and, if s/he thought that the contents of the report warranted it, s/he would draw up a statement of requirements for remedial action over a specified period
- the doctor was invited to agree to undertake the remedial action set out in the statement of requirements
- once the period of remedial action was at an end, the doctor would undergo further assessment.

24.22 In certain circumstances, the case might be referred to the CPP, which would consider the case and would decide whether to direct a performance assessment (if one had not already been carried out) or to impose a sanction on the doctor.

24.23 I shall deal with the various stages in the process separately. I shall describe the process which was in place in late 2003, when the Inquiry heard evidence about the performance procedures.

The Source of Complaints about Performance

24.24 First, I should say something about the complaints received by the GMC in relation to doctors' performance. Most complaints about performance come from doctors' employers (usually NHS trusts) or PCOs. Typically, those NHS organisations will have been attempting for some time to resolve the doctor's problems by means of local procedures, but will have been unsuccessful in doing so. They will usually refer a performance issue to the GMC when they believe that the doctor's deficiencies are so serious that only GMC action on registration will be sufficient to deal with the problem. Alternatively, the doctor may have been unwilling to participate in local remedial action. Sometimes, a NHS body has not had the opportunity to deal with the problem: for example, when a doctor has been employed as a locum and has moved on elsewhere.

24.25 Complaints about performance are sometimes made by postgraduate deans, tutors and advisers, or by a doctor's medical colleagues. Some are also received from patients, although patients' complaints often relate to isolated incidents, rather than to patterns of behaviour. It may be impossible for anyone to know whether the incident complained of, if true, was an isolated lapse or a manifestation of wider performance problems. As I have explained in Chapter 18, until recently, it was not the practice of the GMC, upon receipt of a complaint from a private individual, to make enquiries of the doctor's employer or PCO in order to see whether there had been any other complaints or concerns relating to the doctor. Thus, it is likely that many complaints to the GMC, which were in fact manifestations of wider performance problems, have been screened out because they

were neither serious enough to amount to SPM nor (so far as the GMC knew) part of a pattern which might amount to SDP. It is to be hoped that the arrangements which the Inquiry has been told are now in place for discussions between the GMC and doctors' employers and PCOs at an early stage after receipt of a complaint will lead to greater recognition of the value of patient complaints in revealing evidence of problems with performance.

24.26 Some complaints from patients and a doctor's medical colleagues relate to the performance of doctors in the private sector. Miss Smith told the Inquiry that she could not herself recall a referral from an employer in the private sector, although she could not say that this had never occurred. If it is the case that no or very few such referrals are received, this gives rise to some cause for concern, as it seems unlikely that deficient performance occurs only within the NHS. I can envisage reasons why a commercial organisation might not wish its doctors to become involved with the GMC performance procedures. There might be a fear that the good name of the organisation will be affected if it becomes known that a doctor has been employed about whose performance serious concerns had arisen. Such an organisation might be unwilling to allow the GMC to undertake an assessment of the doctor at his/her place of work. It might simply be easier to dismiss the doctor and to be rid of the problem. This is a cause for concern because, if doctors whose performance gives rise to concern are not reported, they are free to move on and may cause problems for other patients and other organisations.

Consideration of a Complaint by the Staff in the Screening Section

24.27 In recent years, the first stage of the procedures following receipt of a complaint into the Screening Section was for a casework manager to assess, *inter alia*, whether there was any prospect of the complaint being resolved by means of local action. In a potential performance case, the casework manager would wish to ascertain whether local performance procedures had been used and whether there had been any consultation with the NCAA. The November 2002 and April 2003 editions of the FTP Casework Manual (the Casework Manual), prepared for the assistance of staff in the Screening Section, advised that, if it was **'not entirely clear'** that local procedures had been exhausted, casework managers should, at the triage stage, contact the referring body to discuss how the case should be handled. Where there was **'any question of an immediate danger to patients'**, the Casework Manual advised that **'the GMC may need to act'**. The Casework Manual went on to observe that one possible result of such discussion with a referring body was that the referrer would withdraw the referral and take other measures locally before referring back to the GMC if necessary.

24.28 Mr Marshall told the Inquiry that the GMC sometimes received referrals from NHS bodies that wished to put the GMC **'on notice'** that they had got a difficulty with a doctor, but did not consider it necessary to invoke the GMC's conduct or performance procedures at that stage. In other cases, he said that it might be less clear whether the referring body wanted GMC action or not. In that event, GMC staff would contact the referring body and discuss the various options. This might have led to a three-way discussion between the GMC, the referring body and the NCAA. Usually, the initial discussions with the referring body were

conducted by telephone. However, on occasion, it might be necessary to have a meeting. Mr Marshall observed:

> **'I think what we want to achieve by that is to be perfectly happy that all the organisations involved in looking at a particular doctor know what their role is, know the way the thing is going to be taken forward and know exactly what safeguards we might put in place in the meantime.'**

24.29 Mr Marshall told the Inquiry that, until the middle of 2001, GMC staff classified cases as 'performance' or 'conduct' cases at an early stage. Cases that were classified as 'performance cases' were dealt with by a performance screening team and then, if appropriate, the performance assessment team. Cases classified as 'conduct cases' were processed within the Screening Section (which was then part of the Conduct and Screening Section). Mr Marshall said that decisions on classification were made **'too early'** and that had **'led to one or two cases perhaps ending up in the wrong route'**. In mid-2001, a decision was taken to postpone classification until a later stage and to **'leave that decision to the screener'**.

Screening

24.30 After mid-2001, all cases were screened in the same place (the Screening Section). Complaints that suggested that the standard of a doctor's performance might have been seriously deficient were considered by a medical screener. As I have said earlier, medical screeners were also responsible for considering complaints of potential SPM. Once a decision had been taken by the screeners, cases which had been 'screened in' progressed along one of the health, conduct or performance paths. This classification of cases resulted in what the GMC called 'the silo effect'. Once a case was allocated to one set of procedures, it could not always be moved into a different set, even if it transpired later that another set of procedures might have been more appropriate. Under the new FTP procedures, the silo effect should be avoided as, although different methodologies will be used in dealing with the conduct, health and performance aspects of cases, FTP panels will be able to consider all the evidence relating to a doctor at the same time.

The Decision to Be Made by the Screeners

24.31 Rule 5(1)(c) of the 1997 Performance Rules provided that the medical screener should take no action in connection with a case unless the complaint was in writing and unless it:

> **'suggests to the medical screener that –**
>
> **(i) the standard of the practitioner's professional performance may have been seriously deficient; and**
>
> **(ii) it may be appropriate to take action ...'**.

The words **'may be'** were amended in November 2002 to read **'is'**. Also in November 2002, rule 5 was further amended to provide that the medical screener should take no action in respect of a complaint or information received by the GMC five years or more after the events giving rise to it, unless, in his/her opinion, the public interest **'requires'**

action **'in the exceptional circumstances of the case'**. That amendment had the effect of introducing into the performance procedures a 'limitation period' similar to that which was introduced at the same time for the conduct procedures.

24.32 The **'action'** which the medical screener had to decide whether or not to take consisted of the issuing of an invitation to the doctor to undergo a performance assessment. The threshold for issuing an invitation to a doctor to undergo an assessment was a low one. The complaint had to **'suggest'** to the medical screener that the standard of the doctor's conduct **'may have been seriously deficient'** and the complaint had to **'suggest'** to the medical screener that it was (until November 2002, **'may be'**) 'appropriate' to take action.

The 'Rule 5 Letter'

24.33 Until November 2002, before making a final decision whether to invite a doctor to undergo a performance assessment, it was necessary to give him/her notice of the fact that such a course was being considered and to afford him/her an opportunity to submit any observations s/he might have. A 'rule 5 letter' would be sent to the doctor, together with copies of the complaint and of any previous complaint(s) to be taken into account (see paragraph 24.36) and a copy of any statutory declaration (if the complainant was a private individual). The medical screener would then take any observations submitted by the doctor into account when reaching his/her decision whether an assessment should take place. The 1997 Performance Rules provided no opportunity for the complainant (whether a private individual or a public body) to respond to the doctor's observations. Sometimes, receipt of the doctor's observations resulted in a change of mind on the part of the medical screener. For example, in 2000, out of 126 cases in which a 'rule 5 letter' had been sent, medical screeners decided not to pursue 12 cases after receipt of the doctor's observations. In November 2002, an amendment to the 1997 Performance Rules removed the obligation to seek preliminary observations from the doctor and the 'rule 5 letter' was no longer required.

The Power to Seek Further Information

24.34 Rule 5(2) of the 1997 Performance Rules provided that, for the purposes of considering a case, the medical screener might seek information about or observations on the case from any person who, in the opinion of the medical screener, might assist him/her in deciding whether there might be reason to believe that the standard of the doctor's professional performance had been seriously deficient. Thus, it was open to the medical screener to initiate enquiries to assist him/her in making the decision as to whether the case should proceed to an assessment. This was in contrast with the position in a case of potential SPM, where the medical screener had no such specific power.

The Involvement of a Lay Screener

24.35 Rule 5(6) of the 1997 Performance Rules required that, before a decision was taken by the medical screener that no action was needed, a lay screener should be consulted and should agree. If the lay screener did not agree that no action needed to be taken, an invitation to undergo a performance assessment had to be issued.

Consideration of an Earlier Complaint

24.36 Where the screeners decided to take no action in relation to a complaint, rule 4 of the 1997 Performance Rules provided that the complaint might nonetheless be taken into account by a medical screener in connection with the consideration of any subsequent complaint, with a view to determining whether **'together they indicate a pattern of professional performance which is seriously deficient'**. However, when considering a subsequent complaint, an earlier complaint could be taken into account only if, at the time that the doctor was notified that no further action was to be taken in relation to it, s/he was sent a statement informing him/her that the earlier complaint might be taken into account if in the future a further complaint was received. A copy of that statement had to be sent to the person or body who made the earlier complaint, together with an explanation of the reason why a decision had been made to take no action in relation to that complaint. The 1997 Performance Rules imposed no time limit after which an earlier complaint could not be considered. This was in contradistinction to the position where complaints of misconduct or reports of convictions were not acted upon immediately; they could be revived only within two years of the decision to take no action. It seems that, from the first, however, the GMC operated an informal 'cut-off period' of three years for performance cases.

The 1997 Screeners' Handbook

24.37 At the time that the performance procedures came into operation, the first Handbook for screeners, the 1997 Screeners' Handbook, was produced. The Handbook advised medical screeners that a complaint should be treated as a potential performance case only after the medical screener had concluded, first, that referral to the health procedures was not justified and, second, that the case should not be pursued as a case of SPM. A lay screener had to endorse the second conclusion. Only then could the medical screener go on to consider whether there was evidence of SDP. If there was, the medical screener should consider action under the performance procedures. It was open to medical screeners, exercising their powers under rule 5(2) of the 1997 Performance Rules, to ask the GMC staff to make enquiries to establish if the complaint was an isolated one or if there was a pattern of concern locally about the doctor. The 1997 Screeners' Handbook suggested that information might be obtained from the medical adviser or chief executive of a GP's PCO, from the medical director of a NHS trust, from a senior medical executive of an employing organisation, from the chairman or secretary of the LMC or from the chairman of the medical staff of a hospital. The Handbook emphasised the need for **'tact and discretion'** and for confidentiality when making such enquiries. The doctor concerned was to be informed of the complaint before such enquiries were made. It was to be explained to the person from whom information was being sought that the GMC was simply making preliminary enquiries and that no decision about possible GMC action had yet been taken. Any approach made, and the outcome, was to be recorded. All this seems very sensible. However, the evidence I have heard suggests that it did not happen in practice. Until May 2004, when a single complaint was received (which was not serious enough in itself to raise a question of SPM), it was closed without any enquiries being made of local organisations with a view to finding out whether or not there were other concerns about the doctor. I discussed this problem in Chapter 18 and recorded the

reaction of Dr Korlipara to the suggestion that such enquiries should be made. In short, he thought that it was not for the GMC to go 'fishing' for information from which to construct a case against a doctor. From May 2004, the GMC has announced its intention, in certain circumstances, to consult with employers and primary care trusts (PCTs) at an early stage after receiving a complaint.

24.38 In deciding whether a complaint should be taken forward, screeners were advised to consider:

> '• **Is there good evidence relating to the doctor's performance since 1 July 1997, that the doctor may be repeatedly or persistently failing to comply with the professional standards appropriate to the work the doctor is doing?**
>
> • **Does that evidence suggest that there may be a pattern of deficient performance, as opposed to evidence only of one or two incidents of deficient performance, which could be isolated lapses?**
>
> • **Are the alleged deficiencies so serious that, if they cannot otherwise be resolved, there might be grounds for suspending or imposing conditions on the doctor's registration?'**

24.39 Screeners were enjoined to be **'particularly concerned'** where the evidence suggested that the standard of the doctor's professional performance might be placing patients in jeopardy, or where the doctor was repeatedly and persistently failing to comply with the GMC's guidance in 'Good Medical Practice'.

24.40 The Screeners' Handbook advised medical screeners that, in a case where the allegations contained in the complaint did not, in the medical screener's view, warrant action under the performance procedures (the example given in the Handbook being an **'isolated lapse'** in performance with no **'pattern'** of SDP), informal action under Chapter XV of the GMC's Standing Orders might be appropriate. I described the Chapter XV procedures in Chapter 19.

Screening Decision Forms

24.41 As I have explained in Chapter 19, in 1999, the screeners began to use screening decision forms (SDFs) which had been designed by the Policy Studies Institute (PSI) in consultation with the GMC. The purpose of the SDFs was to introduce greater structure and consistency into the screening process.

24.42 The version of the SDF in use from June 1999 until August 2001 contained this advice to screeners:

> **'SDP is normally indicated by a repeated or persistent failure to comply with relevant professional standards.'**

24.43 After August 2001, the advice was changed to read:

> **'SDP is normally indicated by a pattern of serious failure to comply with relevant professional Standards.'**

I was concerned about that change, at least if it was taken literally by screeners. Surely a single **'serious failure to comply with relevant professional standards'** would warrant action under the conduct procedures, as it would raise a question of SPM. The difference between SDP and SPM was that SDP might be evidenced by a series of failures which, taken individually, would not warrant action but which would do so when considered collectively. The new guidance appeared to import a requirement of both seriousness and repetition before SDP could arise. It seemed to me that this might not afford adequate protection for patients.

24.44 However, this change in language might not have had any adverse effect upon the decisions of medical screeners because, at the same time, other advice was given which appeared not to suggest the need for seriousness as well as repetition. From August 2001, the SDF contained a list of criteria which, it stated, were **'not exhaustive but may be an indicator of sdp'**. The medical screener was invited to tick all those criteria that applied to the complaint being screened. The criteria were:

- a tendency to use inappropriate techniques
- a lack of basic knowledge/poor judgement
- a lack of familiarity with basic clinical/administrative procedures
- a failure to keep up-to-date records
- a lack of insight
- a range of inadequacies, namely:
    - outdated techniques
    - attitude
    - inadequate practice arrangements
    - concerns over referral rates
    - poor record keeping
    - inadequate hygiene arrangements.

24.45 The medical screener then had to decide whether the case raised an issue of SPM (in which case it should have been referred to the Preliminary Proceedings Committee) or whether there was a suggestion that there might have been SDP (in which case an invitation to undergo a performance assessment should have been sent). If the medical screener could not judge whether either was applicable, further information might be required. If the medical screener believed that the case raised issues of both SPM and SDP, s/he had to declare whether, in his/her view, the case should proceed by way of the conduct or the performance procedures. The November 2002 Screeners' Handbook (and the subsequent April 2003 version which was still in use at the time of the Inquiry hearings) observed that, in many cases, this would be **'a fine judgement'**. If the medical screener decided that the case raised no issues of SPM or SDP, the agreement of a lay screener had to be obtained before the case was closed.

Invitation to the Doctor to Undergo a Performance Assessment

24.46 If the medical screener decided that the case should proceed, the 1997 Performance Rules required the doctor to be informed of the fact. Until November 2002, under the provisions of rule 6, the doctor (who would already be aware of the complaint and of the fact that an invitation to undergo assessment was being considered, having received the 'rule 5 letter') would be sent a statement setting out the reasons why the medical screener considered that an assessment was necessary. He or she would also be sent a copy of any further information which had been obtained as a result of any further enquiries initiated by the medical screener and taken into account by the medical screener when making his/her decision. Until November 2002, the 1997 Performance Rules provided that the complainant should not be sent the medical screener's statement or any of the information referred to above.

24.47 From November 2002, when the 'rule 5 letter' was abolished, the letter sent after the medical screener's decision could be the doctor's first notification that a complaint had been made to the GMC about his/her performance. The amended rule 6 required the doctor to be sent all the information which would previously have been enclosed with the 'rule 5 letter', together with the invitation to undergo assessment sent in accordance with rule 6.

24.48 The doctor would then be invited to agree within 28 days (until November 2002, the period was 14 days) to an assessment being carried out and to submit within the same period any observations that s/he might wish to make on the case. If the doctor agreed to the carrying out of a performance assessment, the case would be passed to the Performance Section, where arrangements for the assessment would be put in train. If the doctor did not agree to an assessment within the specified period, the medical screener could refer the case to the ARC. Alternatively, having considered the doctor's observations or other information, the medical screener might decide (subject to the agreement of the lay screener) that no further action needed to be taken in connection with the case. Miss Smith told the Inquiry that she was not aware of a case where a medical screener had changed his/her original decision at this stage.

Consideration of the Case by the Assessment Referral Committee

24.49 The 1997 Performance Rules provided that a referral to the ARC might be reversed if the doctor subsequently agreed that an assessment should be carried out or if the medical screener subsequently received information which caused him/her (with the agreement of the lay screener) to decide that no further action needed to be taken in connection with the case. However, if the referral was not reversed, the ARC would proceed to consider the case.

The Composition of the Assessment Referral Committee

24.50 The composition of the ARC was governed by the General Medical Council (Constitution of Fitness to Practise Committees) Rules Order of Council 1996 (the 1996 Constitution Rules), as amended. It comprised 17 members. It was chaired by the President, or some

other member of the GMC appointed by him. Two members were appointed by the President to act as Deputy Chairmen. The appointments made by the President had to be approved by the full Council. The remaining 14 members were elected annually. From August 2000, medical and lay screeners were not eligible for election to the ARC. The total membership of the ARC comprised 13 medical and four lay members. Until November 2002, the legal quorum for the ARC was five, including at least one lay member. After that time, the quorum was three and had to include at least one medical and one lay member.

The Provision of Legal and Medical Advice

24.51 The ARC sat with a legal assessor and with at least one specialist adviser appointed by the Chairman from a panel appointed by the GMC. At least one of the specialist advisers had to be a person who was practising or had practised in the specialty in which the doctor whose performance was under scrutiny generally practised. The function of the specialist adviser was to advise the ARC on the medical issues before it. He or she would give advice on any question referred to him/her by the ARC. In addition, s/he could give advice on his/her own initiative if it appeared to him/her that, but for such advice, there was a possibility of a mistake being made, either in judging the medical significance of any information before the ARC or because of the absence of information. The advice of the specialist adviser had to be given in the presence of the doctor and his/her representative, if they attended the hearing. If the advice was given after the ARC had begun to deliberate as to its findings, the specialist adviser was required to inform the doctor what advice had been given in his/her absence.

The Functions of the Assessment Referral Committee

24.52 Mr Howes said that that the original purpose of the ARC had been to provide a safeguard against the GMC becoming 'trigger happy' and sending doctors for assessment when the evidence did not justify it. The task of the ARC was not to determine whether or not a doctor's performance was seriously deficient. Rather, its functions under rule 15 of the 1997 Performance Rules were to decide whether the standard of a doctor's performance **'may have been seriously deficient'** and, if so, to decide whether an assessment **'needs to be carried out'**. This test appeared to set a slightly higher threshold than that set by the screening test, which required that the complaint should **'suggest'** to the screener that the doctor's performance might have been seriously deficient and that **'it is** (*formerly* **'may be'**) **appropriate to take action'**. Mr Marshall told the Inquiry that the test for the ARC (in contrast to that applied by the screeners) was twofold. If the ARC decided that a doctor's performance might have been seriously deficient, it then had to ask whether, 'despite that', it 'would not want to assess this particular doctor'.

The Procedure at a Hearing before the Assessment Referral Committee

24.53 At a hearing before the ARC, the GMC was represented by a solicitor or counsel. Both the complainant and the doctor were also entitled to be represented. Before the hearing, members of the ARC would receive copies of the document sent to the doctor under the provisions of rule 6 (previously rules 5 and 6) and of any observations from, or further correspondence with, the doctor.

24.54 Hearings of the ARC were held in private. The ARC might obtain any information in writing, or call any person to give oral evidence, which it considered might assist it in carrying out its functions. The complainant could give evidence and s/he or his/her representative could address the ARC. The complainant was not, however, entitled to hear the other evidence adduced before the ARC. Mr Marshall told the Inquiry that most performance cases arose as a result of referrals from public bodies. The referring body would be invited to send a representative to the hearing before the ARC. It was not, however, usual for that representative to give evidence. Mr Marshall observed that the GMC would 'make the most vigorous argument it can that the case should proceed, referring to the papers in hand'. He said that it was 'very rare' for the referring body to have anything to add to the papers which the GMC already had. The doctor might give evidence. Except for the complainant, the doctor and any person whom the ARC chose to call, no one else was permitted to give oral evidence. It seems to me to be unfortunate that the complainant (usually the representative of a public body) was not permitted to hear what the doctor had to say. He or she was the person most likely to have detailed knowledge of the case and to know whether or not what the doctor had said was reasonable or was capable of being refuted. It seems to me that that person should have been present throughout the hearing so that, if appropriate, s/he could communicate with the GMC representative.

24.55 If, at the conclusion of the evidence, the ARC decided that a performance assessment needed to be carried out, it would direct that an assessment should be conducted and the case would immediately pass to the Performance Section for the appropriate arrangements to be made.

24.56 If the ARC decided that no assessment was necessary, the case would be closed. A decision by the majority of members was taken as the decision of the ARC. If the votes were equal, the Chairman had an additional casting vote. The ARC was not required to give reasons for its decisions and, if it found in favour of the doctor, did not do so. This absence of reasons gave rise to a considerable amount of concern on the part of NHS bodies who were given no explanation of why a decision (contrary to that of the medical screener) had been taken not to take action in a case which they had regarded as serious enough to refer to the GMC. I shall return to this topic later in this Chapter.

The Performance Assessment

The Appointment of a Case Co-ordinator

24.57 Once it had been decided that a performance assessment should be carried out, the 1997 Performance Rules required the appointment of a case co-ordinator. Until July 2003, the case co-ordinator had to be a medical member of the GMC. In practice, the GMC authorised two of the medical screeners to act in that capacity. The first performance case co-ordinators were Dr Robin Steel (the principal medical screener) and Professor Hilary Thomas. In March 2004, two of the recently appointed medically qualified case examiners were appointed as performance case co-ordinators, pending the introduction of the new FTP procedures. The first function of a case co-ordinator was to appoint the members of the Assessment Panel which was to carry out the performance assessment. Panel members were appointed from the list of performance assessors who had been authorised by the GMC to carry out performance assessments.

Performance Assessors

24.58 Performance assessors are not members of the GMC. They are medically qualified and lay people who have been selected and trained by the GMC to act as assessors. Initially, 400 people (250 medical and 150 lay) were selected, of whom only half were trained immediately. Others were trained as the need for more people to participate in assessments increased. Performance assessors receive intensive training (including a five-day residential course) in their role. After their initial training, they receive ongoing training and support at workshops and other events. In addition, assessors who are not on the GMC's list have also been appointed on an *ad hoc* basis to assist with individual assessments. Both Sir Donald Irvine and Dame Lesley Southgate emphasised the value of the participation by lay people in the assessment process.

The Assessment Panel

24.59 Members of staff in the Performance Section would send to the doctor a 'portfolio' to complete. The doctor would be asked to provide a description of the nature of his/her practice, an account of his/her professional training and experience and other details. The staff would then attempt to identify suitable members for the Assessment Panel. The case co-ordinator would approve the constitution of the Assessment Panel and would formally appoint the panel members before the assessment took place.

24.60 Under the 1997 Performance Rules, Assessment Panels had to consist of two doctors and a lay person, with a doctor as the lead assessor. The lead assessor would be a doctor from the same specialty as the doctor being assessed. From November 2002, the Rules provided that, where an assessment was to include **'structured tests of the doctor's professional knowledge and skills'** (which, as I shall explain, usually constitute Phase II of the assessment), the case co-ordinator could appoint one or more additional members to the Assessment Panel. Those members would be involved in the assessment only for the purpose of assessing the doctor's performance in those tests. The appointment of additional members for this purpose ensured that the assessment of the doctor's performance in Phase II was approached with a fresh eye and without any preconceptions based on his/her performance in Phase I.

The Work of the Assessment Panel

24.61 The Assessment Panel would be provided with all the relevant papers in the case, including the original complaint and the doctor's observations on it. The Assessment Panel would tailor the way in which it carried out the assessment to the individual circumstances of the doctor being assessed. The 'portfolio' completed by the doctor assisted in this process. During the assessment, performance assessors might act alone or in different combinations.

24.62 Phase I of the performance assessment was known as the 'peer review'. It usually occupied about two and a half days. The performance assessors would interview the doctor, usually on several occasions. On at least one such occasion, the doctor had to be interviewed by all members of the Panel together. The doctor was entitled to be

accompanied at interviews with the performance assessors, save when details of particular cases of named patients were being discussed. Panel members would also interview the complainant (if s/he agreed) or, if the complainant was (as was usually the case) a public body, they would interview a representative of that body and possibly the members of staff with direct knowledge of the matters giving rise to the concerns or complaint. The Assessment Panel would visit the doctor at his/her place of work (if applicable) and would inspect a number (usually about 50) of sample sets of his/her medical records. From those records, the Panel would select certain cases which would subsequently form the basis of detailed discussions with the doctor. They might also observe how the doctor conducted consultations with patients. If the complaint related to a hospital doctor's surgical skills, the performance assessors might observe him/her at work in the operating theatre. Performance assessors would also speak to a doctor's colleagues and to others with firsthand knowledge of the doctor's performance; these might be nurses, practice staff (if the doctor was a GP) or senior managers (if the doctor worked in a hospital). The 1997 Performance Rules provided that the doctor might nominate no more than five persons whom s/he wished to be interviewed in the course of the assessment and the Assessment Panel was required to make reasonable efforts to ensure that those persons were interviewed by at least one Panel member. During the assessment, performance assessors might act alone or in different combinations. As the assessment progressed, the assessors would enter their comments in a specially designed database. They graded each entry as 'acceptable', 'cause for concern' or 'unacceptable'. 'Acceptable' meant that the evidence demonstrated that the doctor's performance was consistently above the standard for fitness to practise. 'Cause for concern' meant that there was evidence that suggested the performance might not be acceptable but there was not sufficient evidence to suggest SDP. 'Unacceptable' indicated that there was evidence of SDP.

24.63 The 1997 Performance Rules required the Assessment Panel to disclose to the doctor any written information or opinion received by the Panel which the Panel believed might influence its assessment, and to give the doctor an opportunity of commenting on it. The practice was that all interviews with third parties were transcribed. In the past, transcriptions of third party interviews were not always made available to the doctor while the assessment was in progress. Following the judgement in the case of Sadler v General Medical Council[3], given in July 2003, it became clear that this must be done, so that the doctor could have an opportunity to comment on the content of those interviews before the final assessment report was prepared.

24.64 Phase II of the performance assessment consisted of tests of competence which were designed to suit the doctor's specialty. Phase II consisted of a test of knowledge, a simulated surgery with trained actors playing the role of patients, and objective structured clinical examinations (OSCEs), whereby the doctor was placed in certain clinical situations to which s/he had to react. The GMC has recently opened a new assessment centre for the assessment of doctors coming to practise in the UK from overseas. Mr Scott told the Inquiry that it was intended that the assessment centre should also be used in the future to conduct Phase II of performance assessments.

[3] [2003] 1 WLR 2259.

24.65 The doctor's scores on the Phase II tests were assessed against a control group of doctors in the same specialty who had completed the same tests. The minimum scores for the tests were deliberately set low, well below those that would be attained by the vast majority of doctors. For example, 75% of GPs would have scored 85% or above in the knowledge test but the score that gave rise to a 'cause for concern' in the assessment was set at 68.8%. Similarly, 75% of GPs would score over 72% in the simulated surgery tests, whereas the score that gave rise to 'cause for concern' in the assessment was set at only 50%. In the OSCEs, 75% of GPs would score over 80%, but the score giving rise to 'cause for concern' was set at 70%[4].

24.66 The doctor was asked to proceed to Phase II only if, as a result of Phase I, the Assessment Panel considered that there was a potential problem with the doctor's performance. If the Assessment Panel agreed at the conclusion of Phase I that the doctor's performance was not seriously deficient and that nothing would be gained by proceeding to Phase II, the assessment would be halted there. At the Inquiry, there was some discussion about whether it would be sensible to reverse the order in which the two Phases were conducted. Phase I was very 'resource-intensive' and, therefore, very expensive. It could often take quite a long time to set it up and, as a result, delays occurred. Phase I also depended to a very large degree on subjective judgements about the reliability of observations made by interviewees. On the other hand, Phase II was more objective. The argument for change was that, if a doctor performed well (or even adequately) in the objective tests, the Panel might well be able to reach the conclusion that no real concerns arose. If s/he performed inadequately, s/he would have to complete the assessment process (the present Phase I). Such a change would produce savings in both cost and time. It seemed to me that the most important consideration was whether the taking of the Phase II objective tests would provide a reliable indicator on the basis of which it would be safe to make a decision to discontinue the process. Dame Lesley Southgate was of the view that it would not be safe. She said that a doctor cannot perform well unless s/he has a sound knowledge base. However, the converse is not true; a doctor with a sound knowledge base can still perform badly. It appears, therefore, that there is no easy answer to problems of resources resulting from the Phase I assessment.

24.67 In the past, there were very severe delays in carrying out assessments and in producing the reports. In August 2001, a service standard was introduced with a target of completing an assessment within five months of the doctor having agreed to, or been directed to, undergo it. However, assessments could still take longer to complete, particularly if it was difficult to find suitable assessors who were available.

24.68 The form of the performance assessment was reviewed from time to time. Miss Smith told the Inquiry that, from a time shortly before she gave evidence, the practice had been to conduct more case-based discussions with the doctor and to cut down on the number of interviews with third parties. Recent experience had suggested that the reliability of third party interviews and/or the impartiality with which they were recorded might be successfully attacked by the doctor at a hearing before the CPP. Suspicions had arisen

[4] Southgate L, Campbell M, Cox J, Foulkes J, Jolly B, McCrorie P, Tombleson P (2001) 'The General Medical Council's Performance Procedures: the development and implementation of tests of competence with examples from general practice', Medical Education, Vol 35 (Suppl. 1): pp 20–28.

that some complaints had been made as the result of a particular doctor being made the scapegoat for a problem within a department or even as the result of racial discrimination. It is clear that the accounts given by members of staff or patients to an Assessment Panel cannot be subjected to cross-examination and there must be a danger that the Panel might be less than objective in its judgements. Where judgements are based on what the doctor him/herself said about his/her cases, these risks would be much reduced. Also, the results of Phase II, being calibrated by reference to the performance of a large number of doctors, would provide objective and reliable material.

24.69 The 1997 Performance Rules required all members of the Assessment Panel to meet together during the assessment to review its progress. They were then required to meet again to consider the conclusions to be reached on the assessment and the content of their report.

24.70 Once completed, the performance assessment report was sent to the case co-ordinator unless the assessment was carried out in accordance with the direction of the CPP (see paragraph 24.93, in which case the report was sent to the CPP. The report had to include the opinion of the Assessment Panel on some or all of the following matters, namely whether:

> **'(a) the standard of the practitioner's professional performance has been seriously deficient;**
>
> **(b) the standard of the practitioner's professional performance is likely to be improved by remedial action;**
>
> **(c) the practitioner should limit his professional practice, or cease professional practice;**
>
> **(d) no further action needs to be taken on the Report.'**

24.71 An Assessment Panel was required to give its reasons for the opinions expressed. If members of the Panel disagreed, the 1997 Performance Rules required that the report should include a statement of any dissenting opinion and the reasons for it.

Failure to Co-operate with an Assessment Panel

24.72 If a doctor did not co-operate with the Assessment Panel, his/her case would be referred to the CPP. Sometimes, it was not easy to know whether the doctor was failing to co-operate or whether there was some genuine difficulty giving rise to that impression. It was not unusual for a doctor to assert that s/he was ill while the performance assessment was going on. In those circumstances, the case co-ordinator had to make a judgement as to whether the doctor's conduct in reality amounted to a deliberate failure to co-operate or whether the assessment should be postponed to allow his/her health to improve. It was recognised that being the subject of assessment can be extremely stressful and that this might have a genuine effect upon a doctor's health. If necessary, the case could be referred to the CPP and the CPP could consider referring the case to the Health Committee

(HC). Miss Smith said that staff in the Performance Section tried 'not to leave cases lingering for months on end without resolution'.

Consideration of the Performance Assessment Report

Seeking the Doctor's Observations on the Assessment Report

24.73 When the case co-ordinator received the assessment report, s/he was required to send a copy to the doctor, together with an invitation to submit written observations on it within 21 days. At the expiration of that period, the case co-ordinator had to consider the report and any observations submitted by the doctor. It should be noted that the 1997 Performance Rules specifically provided that the complainant should not receive a copy of the assessment report. This was the case even though the complainant was usually the doctor's employer or PCO and might have been able to make observations every bit as germane to the issues as those of the doctor.

The Decision Made by the Case Co-ordinator: No Further Action

24.74 In making his/her decision on the appropriate course of action to be adopted after receipt of the assessment report, the case co-ordinator was not bound by the Assessment Panel's opinion, although it would form a central part of his/her consideration. Miss Smith told the Inquiry that case co-ordinators did sometimes take a different view from that of the Assessment Panel. The Inquiry has seen the papers in one such case, that of Dr KA 05. However, Miss Smith observed that it did not happen very often.

24.75 The case co-ordinator had three options open to him/her. The first option was to close the case without further action. If the case co-ordinator was of the opinion that no further action should be taken in the case, s/he was required to consult a lay adviser before closing the case. A lay adviser was a lay member of the GMC appointed to act for this purpose. Only if the lay adviser agreed could the case be closed without further action. If the lay adviser did not agree with the case co-ordinator, the case co-ordinator had to refer the case to the CPP together with a copy of the performance assessment report, a statement of his/her opinion and a statement of the opinion of the lay adviser. A decision by a case co-ordinator (and agreed by a lay adviser) to take no further action was likely to arise only when the Assessment Panel had reported that the doctor's performance had not been seriously deficient. Miss Smith told the Inquiry that it was her impression that it was unusual for an Assessment Panel to find that the doctor's performance had not been seriously deficient. However, the GMC's FTP statistics do not entirely bear this out. In 2002, 21% of assessments resulted in a finding that the doctor's performance was acceptable. In 2003, the figure was 31%. Dame Lesley Southgate told the Inquiry at the seminars that it sometimes appeared that complaints of poor performance against a doctor had been made as the result of victimisation of one sort or another, rather than because his/her performance was deficient.

24.76 When an Assessment Panel reported that there had been practice which, although unacceptable, did not in the Panel's view amount to SDP, Miss Smith said that the case co-ordinator would have no option but to close the case. She said that no other action

would be taken. The effect of this was that the doctor's employers or PCO (and, if s/he was a GP, other members of the practice) would not be informed of any continuing concerns about the doctor's unacceptable practice, as revealed by the performance assessment, or given any advice about the steps they might take to deal with it.

The Decision Taken by the Case Co-ordinator: Referral to the Committee on Professional Performance

24.77 The second option open to the case co-ordinator was to refer the case to the CPP. Rule 25 of the 1997 Performance Rules required a case co-ordinator to refer a case to the CPP if, at any stage after an assessment had been carried out, s/he was of the opinion that it was necessary for the protection of members of the public or would be in the best interests of the practitioner for a direction for suspension or for conditional registration to be made.

24.78 The case co-ordinator would usually refer a case to the CPP if the Assessment Panel had reported that there were serious deficiencies in the doctor's performance which were unlikely to be improved by remedial action. In certain circumstances, the case co-ordinator might decide to refer a case, despite the Panel's view that remedial action was likely to be effective.

The Decision Taken by the Case Co-ordinator: a Statement of Requirements

24.79 The third option for the case co-ordinator was to formulate a written statement of requirements, with which the doctor would be invited to agree to comply. The doctor's agreement would usually include an agreement to take certain specific steps to remedy identified deficiencies. It might also involve agreeing to limitations being placed on his/her practice. In considering whether to deal with a case by way of a statement of requirements, a case co-ordinator would consider whether a statement of requirements would sufficiently protect patients. A statement of requirements was, the Inquiry was told, unlikely to be considered where the doctor did not admit the Assessment Panel's findings or where s/he showed limited insight into his/her deficiencies. Miss Smith said that the presence or absence of insight and the seriousness of the problems identified were the two most important factors she would have expected a case co-ordinator to have in mind when deciding whether a statement of requirements was appropriate.

The Statement of Requirements

24.80 If the case co-ordinator decided that a statement of requirements was appropriate, s/he would proceed to draw it up and send it to the doctor. The statement had to be based on the findings and opinion in the performance assessment report and might, as the case co-ordinator deemed appropriate, include any or all of the following matters:

> **'(a) the aspects of the practitioner's professional performance which he is required to improve;**
>
> **(b) the standard of professional performance which the practitioner is required to achieve;**

(c) the aspects of the arrangements for the running of his professional practice which the practitioner is required to improve;

(d) the limitations which the practitioner is required to impose on his professional practice'.

24.81 The statement might require the doctor to undertake training in some aspect of his/her practice and might also specify limitations on his/her practice, to which the doctor had to agree. The statement also had to set out the date on which the doctor was expected to have fulfilled any requirements and the period for which the statement of requirements was to have effect. It was also required to include a provision that further assessment was to be carried out after the date on which the doctor was expected to have fulfilled the requirements. That date had to be no later than a year from the date on which the doctor agreed to comply with the statement of requirements.

24.82 The 1997 Performance Rules provided that, where the doctor agreed to comply with the statement of requirements, s/he must signify his/her agreement in writing within 14 days and must undertake to comply with the statement of requirements and to undergo reassessment after the date on which s/he was expected to have fulfilled the requirements. The doctor was also required to agree to his/her employer or professional partner or **'any organisation or person with whom s/he has a professional relationship'** being told by the GMC of his/her agreement to comply with the statement of requirements and of the nature of those requirements. It appears that patients were not deemed to be included in the classes of persons with whom the doctor had **'a professional relationship'**, so that they would not be informed automatically. However, the doctor had to agree to the GMC disclosing the information to any person who made a specific enquiry about his/her registration. This rule was designed to ensure that doctors who were dealt with by way of a statement of requirements entered into voluntarily were put on a par with doctors who were the subject of directions made by the CPP. Such directions would be discloseable in response to enquiries about the doctor's fitness to practise. So, a patient who 'got wind' of the imposition of requirements could find out about them but patients were not automatically told. As I have said, the doctor's employers, partners and the PCT were not entitled to see the performance assessment report itself. This applied even where the doctor had agreed to a statement of requirements. If a doctor did not signify within 14 days his/her written agreement to comply with the statement of requirements, the case co-ordinator would refer the case to the CPP.

Compliance with the Statement of Requirements

24.83 Once the doctor had undertaken to comply with the stated requirements, it was up to the doctor him/herself to address any deficiencies that had been identified and to arrange to undergo any necessary retraining or education. He or she was expected to liaise with the regional postgraduate dean or with the regional director of postgraduate education for this purpose. Miss Smith told the Inquiry that it could be difficult for doctors to make these arrangements. Locums could experience particular difficulty obtaining the support necessary to fulfil the requirements. I shall refer to these difficulties later in this Chapter. Miss Smith also told the Inquiry that it was customary for a case co-ordinator to require a

quarterly report on the progress of the doctor from a person assisting in his/her re-education programme, to ascertain whether the doctor was complying with the requirements.

24.84 Rule 25 of the 1997 Performance Rules required the case co-ordinator to refer a case to the CPP if, in his/her opinion, the doctor was failing to comply with the requirements set out in the statement of requirements or if s/he was failing to benefit from and was unlikely to benefit from any education or training which s/he was undertaking in accordance with the statement of requirements.

24.85 The case co-ordinator was also required to refer a case to the CPP where s/he was of the opinion that the practitioner's fitness to practise might be seriously impaired by reason of his/her physical or mental condition. A case co-ordinator had no power to refer the doctor direct to the HC or into the voluntary health procedures.

Modification of the Statement of Requirements

24.86 The 1997 Performance Rules permitted the case co-ordinator to modify the statement of requirements with the agreement of the doctor. If the doctor did not agree to such modification, the case co-ordinator could refer the case to the CPP or could notify the doctor that the original statement of requirements would continue to have effect.

Further Assessment of the Doctor's Performance

24.87 The 1997 Performance Rules also provided for a further assessment to be carried out at the end of the period covered by the statement of requirements. A second Assessment Panel was appointed by the case co-ordinator as before. This assessment would focus on the deficiencies identified in the first Assessment Panel report and on the requirements contained in the statement.

24.88 The task of the second Assessment Panel was to assess whether the doctor had satisfactorily fulfilled the requirements of the statement and whether, as a result, the standard of his/her performance had improved sufficiently to enable the Assessment Panel to suggest that no further action should be taken. In the course of the second assessment, the Assessment Panel was required to interview the doctor and to consider any information about, or observations on, the case which were received from anyone who had assisted the doctor with any advice, education or training in connection with any remedial action taken by the doctor during the period of the statement of requirements. The report of the Assessment Panel was then sent to the case co-ordinator.

24.89 On receipt of the second Assessment Panel report, the case co-ordinator was required to decide, as before, whether to refer the case to the CPP, to take no further action in the case (only with the agreement of a lay adviser) or to seek the doctor's agreement to a second statement of requirements. Miss Smith said that, in her experience, if a second Assessment Panel felt that the doctor had not demonstrated that s/he had improved, the case co-ordinator would be reluctant to agree another statement of requirements and would be more inclined to refer the case to the CPP. If, however, some progress had been made, the case co-ordinator might give the doctor more time to make further

improvements. The 1997 Performance Rules provided for the possibility of a third assessment to be arranged in the same way as previously described.

Consideration of the Case by the Committee on Professional Performance

24.90 The 1997 Performance Rules provided for the reversal of a referral to the CPP in an appropriate case, e.g. if the doctor changed his/her mind and agreed to an assessment, or if the case co-ordinator received information which caused him/her to believe that it was no longer necessary for the CPP to hold an inquiry into the case. However, if the referral was not reversed, the CPP would proceed to consider the case.

The Composition of the Committee on Professional Performance

24.91 The composition of the CPP was governed by the 1996 Constitution Rules as amended. The CPP consisted of 26 members. It was chaired by the President or by a GMC member appointed by him. Two members were appointed by the President as Deputy Chairmen. The remaining 23 members were elected annually. The total membership of the CPP comprised 21 medical members and five lay members. The President's appointments were required to be approved by the Council. The CPP sat in panels. Until November 2002, the legal quorum for a CPP panel was five, including at least one lay member. In November 2002, the quorum was reduced to three, including at least one medical and one lay member. From 2000, non-members of the GMC (known as associates) were permitted to sit on the CPP and did so regularly. After July 2003, it was unusual for a member of the GMC to sit on a CPP panel. CPP panels sat with a legal assessor and with at least one specialist adviser.

24.92 The 1997 Performance Rules provided that the proceedings of the CPP should be held in private, unless the doctor requested that they be held in public. This rarely happened. If a hearing was held in public, it was open to the CPP to direct that confidential medical information about any individual should be received in private. In 2000, consideration was given to a change whereby the CPP would sit in public but, after consideration, no such change was thought appropriate. Some information about cases in which the CPP found the standard of a doctor's performance to have been seriously deficient were published from the inception of the procedures. In addition, after July 2003, the minutes of CPP hearings were published.

Assessment Hearings

24.93 Hearings by the CPP might occur where no assessment had been carried out. In a case where no order for an assessment had previously been made by the CPP (i.e. if the doctor had originally agreed to the assessment, then failed to co-operate, or if the ARC had directed the assessment and the doctor had not co-operated), the CPP had to decide whether to direct that an assessment should be carried out. The procedure for such hearings (known as 'assessment hearings') was similar to that for hearings by the ARC. If the CPP had previously directed that an assessment should be undertaken and the doctor had failed to co-operate, it was open to the CPP to suspend or to attach conditions to his/her registration. In such a case, the hearing was similar to that of the ARC, save that

there was no opportunity for the complainant to give evidence. That was because the requirement for an assessment had already been established; the question at issue was why the doctor had not complied with the requirements of the Assessment Panel. Miss Smith said that she was aware of one case when, following an assessment hearing on the grounds of a doctor's failure to co-operate with an Assessment Panel, the CPP had decided that an assessment was not necessary. It was not clear why this decision had been taken as, at that time, reasons were not given for the CPP's decisions. Subsequently, the CPP began to give reasons for its decisions in cases where it found the doctor's performance to be seriously deficient. More recently, it extended the giving of reasons to all cases, whatever the finding.

Performance Hearings

24.94 Hearings before the CPP might also occur when a performance assessment had been carried out and had revealed deficiencies which were so serious that the case co-ordinator considered it appropriate to refer the case to the CPP, or where a lay adviser disagreed with a case co-ordinator's decision to take no action after a performance assessment had been carried out. These hearings were known as 'performance hearings'. Other circumstances in which a performance hearing might take place were where the doctor had failed to agree to comply with a statement of requirements or a modified statement of requirements, or where the case co-ordinator was of the opinion that s/he was not benefiting, or was not likely to benefit, from any education or training s/he was undergoing or where the case co-ordinator believed there might be some health problem.

24.95 So far, I have mentioned only the circumstances in which a case might be referred to the CPP by a case co-ordinator. The 1997 Performance Rules also provided for a doctor to refer his/her own case to the CPP. When a performance assessment had been ordered by the ARC, the doctor could request that the standard of his/her professional performance should be considered by the CPP.

24.96 At a performance hearing, the complainant could be represented and could give evidence and address the CPP. However, the complainant was not entitled to hear other evidence given to the CPP. The GMC's representative was also permitted to call evidence including, usually, evidence from the lead assessor of the Assessment Panel.

24.97 The 1997 Performance Rules stated that, in advance of the hearing, the GMC should provide the doctor with copies of reports, written statements and other documents in the case. The GMC was required to inform the doctor whether or not it intended to call the author of a report, written statement or other document to give oral evidence at the hearing. The doctor then had the opportunity to make further written observations on the case and to indicate to the GMC if s/he wished the author of any of the documents sent to him/her to be called to give evidence. If the doctor wished the author of any relevant documents to be called, arrangements would be made for that person to attend the hearing. The 1997 Performance Rules provided that the lead performance assessor should be treated as the author of the performance assessment report. If s/he was not available to give evidence at the hearing, the case co-ordinator would decide which of the other members of the Assessment Panel should be called to give evidence in the lead

assessor's place. The CPP might itself obtain information in writing or call any person to give oral evidence where it considered this would assist it in carrying out its functions. The doctor might give oral evidence and might call witnesses. Miss Smith told the Inquiry that, in one recent case, the doctor had called 36 witnesses who had been responsible for writing documents relevant to the doctor's case.

The Decision of the Committee on Professional Performance

24.98 The CPP would then decide whether it found the standard of the doctor's performance to have been seriously deficient. If the CPP found that there had been no SDP, the case was closed. There was no power to do anything if the doctor's conduct was found to have been deficient but not, in the view of the CPP, to such an extent as to amount to SDP. Mr Scott, Chief Executive of the GMC, acknowledged in evidence that this was unsatisfactory. In Chapter 25, I will discuss the way in which it is proposed to solve this problem under the new FTP procedures.

24.99 The 1997 Performance Rules provided that the decision of the majority of the CPP who were present constituted a decision of the CPP. If the votes were equal, the decision should be in favour of the doctor. The CPP was not required to give reasons for its decision and did not generally do so when it decided that the doctor's performance had not been seriously deficient. This failure to give reasons was the subject of criticism and the practice has recently been changed. I shall return to this issue later in this Chapter.

24.100 If, having heard the evidence in the case, the CPP took the view that the doctor had or might have been guilty of SPM (as well as or instead of SDP) and that erasure of his/her registration might, therefore, be appropriate, it had no power to refer the case to the PCC. Miss Smith acknowledged that this was 'unsatisfactory'. This difficulty will be solved under the new FTP procedures, as erasure will be available in cases with a performance element.

24.101 If the CPP made a finding of SDP, it would then go on to consider the appropriate sanction. The CPP had no power, once a finding of SDP had been made, to take no action. Nor could it issue a reprimand. It had to impose one of two sanctions: suspension or conditional registration.

Sanctions

24.102 Suspension of a doctor's registration, if imposed, had to be for a specified period not exceeding 12 months. Alternatively, the CPP could impose conditions on the doctor's registration for a period not exceeding three years. In an appropriate case, the CPP could order that a suspension should take effect immediately. The CPP had no power to direct erasure, but, as I have explained, it had the power, in certain circumstances, to direct indefinite suspension.

Remedial Action after the Decision of the Committee on Professional Performance

24.103 If conditions on registration or suspension were imposed, it was for the doctor to initiate action, with the assistance of the postgraduate dean or postgraduate tutor in general

practice, to arrange any necessary re-education or training. No supervision was exercised to ensure either that this was done or that it was done promptly. Miss Smith told the Inquiry that, as at December 2003, no regular report on the doctor's progress was required by the CPP, as was the case when a doctor was dealt with by means of a voluntary statement of requirements. Miss Smith said that the GMC tended to have more contact with a doctor who was practising under a voluntary statement of requirements than with a doctor who was practising under conditions imposed by the CPP. The role of the case co-ordinator was, she said, limited once a case had been referred to the CPP. Sometimes, a person who was supervising the doctor might contact the GMC unprompted. This was usually when things were not going well. In the majority of cases, however, nothing was heard about the doctor's progress until the staff asked for information from the supervisor, or from the local postgraduate dean or postgraduate tutor in general practice, in preparation for a resumed hearing before the CPP. Miss Smith agreed that it would have been a better safeguard if, in a case which had been dealt with by the CPP, there had to be quarterly reports. Alternatively, perhaps, a case co-ordinator could have been appointed within the GMC to supervise the remedial arrangements. Bearing in mind that the CPP dealt with the more serious cases and the cases where the doctor was unwilling to co-operate, it seems strange that the supervision should have been less close following an order made by the CPP than in a case where there was a statement of requirements. In my view, this anomaly requires attention.

24.104 The Inquiry received some evidence about the problems that arose when the GMC imposed conditions upon a doctor's registration and the postgraduate deaneries were expected to provide support and remediation. First, I noted a study[5] of the process and outcomes of referrals from the GMC and health authorities to deaneries over a period of two years. In summary, it was found that, although the information provided to the deanery by the GMC was usually adequate and timely, the GMC sometimes required action that was not appropriate or feasible. Also, in the majority of cases, the cost of remedial training and education had to be borne by the deanery concerned. Letters received by the Inquiry in early 2004 from two different deaneries tended to confirm that these problems still remained. One acting Regional Director of Postgraduate Education told the Inquiry that, when the GMC imposed conditions on a GP, the GP was left to make his/her arrangements with the deanery. It was felt that the doctor's PCT should take an active part in making arrangements and should provide the necessary funding. This deanery felt well equipped to undertake educational remediation but was not prepared to engage in remediation connected with problems of health, attitude or personal circumstances. Another postgraduate dean spoke of similar problems. He confirmed that doctors were left to make their own arrangements for remediation. He said that it was difficult to provide the right environment for remediation and to find doctors willing to undertake the work of supervision and mentoring. He mentioned concerns about exposing patients to poorly performing doctors who might have personality and other problems. Remediation had to be undertaken by experienced doctors, who were already busy with their own practices and had to engage locums to cover the time they spent away from their patients.

[5] Bahrami J and Evans A (2002) 'Underperforming doctors in general practice: a survey of referrals to UK Deaneries', British Journal of General Practice, pp 892–896.

Remediation is necessarily expensive and funding can be a problem, particularly if the doctor is a locum without an established relationship with a PCT prepared to take responsibility. Notwithstanding these difficulties, this deanery had embarked on a programme of recruitment and training of doctors in training practices who would be willing and able to undertake this work. I had the impression, certainly from these respondents, that the spirit of the deaneries was very willing but the resources were scarcer than needed.

Resumed Hearings

24.105 When the CPP suspended or imposed conditions on a doctor's registration, the 1997 Performance Rules required the CPP to state that it would resume consideration of the case at a hearing (a 'resumed hearing') before the end of the period of suspension or conditional registration. The CPP was required to specify what information it would require at the resumed hearing and whether a further assessment should be carried out before the resumed hearing. In practice (and unlike the position where a statement of requirements had been agreed), further assessments were not always required by the CPP. Miss Smith told the Inquiry that it was not unusual for the CPP to direct that some form of assessment should take place but neither was it a particularly frequent occurrence. If a doctor had been suspended, the CPP would expect him/her to have taken steps to remedy the deficiencies in his/her practice before the resumed hearing. The steps the doctor would have been able to take would necessarily be limited by the fact that s/he had not been able to practise during that period. I draw attention to the fact that the CPP was required to hold a resumed hearing before the end of a period of suspension or conditional registration whereas the PCC was not obliged to do so and often did not do so. The Inquiry was told (and has seen an example of one case where it occurred) that, on occasion, a doctor who had previously failed Phase II of the performance assessment (i.e. the tests of knowledge and skills) would be required by the CPP to undergo a Phase II reassessment before being allowed to resume practice.

24.106 The CPP might bring the resumed hearing forward, for example if the doctor was not complying with the conditions imposed on his/her registration. Before the resumed hearing, the 1997 Performance Rules provided for the distribution to the doctor and members of the CPP of any relevant documents which had come into existence since the previous hearing (e.g. a further performance assessment report) and for the doctor to be given the opportunity to request that the author of any relevant document should be called to give evidence at the resumed hearing. The procedure for the hearing was similar to that for the original hearing, save that there was no provision for the complainant to give evidence. At a resumed hearing, the CPP had the power to extend a period of conditional registration for up to three years, to revoke or vary any of the conditions previously imposed or to direct that the doctor's registration should be suspended for up to 12 months. Where the doctor had been suspended at the original hearing, the CPP could extend the period of suspension for up to 12 months or impose a period of conditional registration for up to three years. In a case where the CPP had already directed periods of suspension lasting at least two years, the CPP could make a direction for indefinite suspension. Such a direction might be reviewed at the request of the doctor, but not

before two years after the date on which the direction took effect and not more than once every two years thereafter. In this way, the CPP acquired what amounted almost to a power of erasure.

Referral of a Case to the Health Committee

24.107 The CPP had the power to refer a case to the HC. The doctor would be medically examined and the HC, having considered the results of the examination, would form a judgement about whether the doctor's fitness to practise was seriously impaired by reason of a physical or mental condition. If, in the HC's judgement, there was no serious impairment, it was required to certify its opinion to the CPP. The CPP panel would then resume its consideration of the case and dispose of it. If, on the other hand, the HC's judgement was that the doctor's fitness to practise was seriously impaired by reason of his/her condition, the HC was required to certify its opinion to the CPP and then to proceed to dispose of the case. The CPP would then cease to exercise its functions in relation to the case. By referring a case to the HC for its opinion, therefore, the CPP did not necessarily lose its jurisdiction over a case. If no serious impairment of fitness to practise was found, the CPP could proceed to deal with the case. The CPP had no power to refer a case to a health screener to be dealt with by means of the voluntary health procedures. The ARC had a similar power to refer a case to the HC.

Interim Orders

24.108 Until 2000, there was no provision for the making of an interim order of suspension or for the imposition of interim conditions on registration in a performance case. From August 2000, medical screeners, case co-ordinators, the ARC and the CPP had the power to refer a case to the Interim Orders Committee (IOC) if it appeared to any of them that the IOC might wish to make an interim order. At the same time, the CPP was given the power to amend an order made by the IOC.

Appeals

24.109 Appeals from decisions of the CPP were governed by section 40 of the Medical Act 1983. Until April 2003, a doctor who was the subject of a direction for suspension or for conditional registration (or variation of the conditions imposed by a direction for conditional registration) had a right of appeal to the Judicial Committee of the Privy Council. After April 2003, appeals lay to the High Court. Until 2003, an appeal lay on a question of law only. In 2003, that restriction was removed.

The Operation of the Performance Procedures

24.110 In May 1999 and May 2000, the Performance Section presented reports on the operation of the performance procedures to the full Council of the GMC. Thereafter, statistics relating to cases dealt with under the performance procedures have been included in the annual GMC FTP statistics.

The Numbers of Cases Dealt with under the Performance Procedures

24.111 As I have already mentioned, the performance procedures got off to a slow start. The first cases entered the procedures in the early part of 1998 and, during that year, the GMC initiated action under the performance procedures (the 'initiation of action' being at that time defined by the GMC as the sending of a 'rule 5 letter' to the doctor) in ten cases. In May 1999, nine doctors had agreed to be assessed or had been required by the ARC to undergo assessment. Only three full assessments had been completed. During 1999, action was initiated by the GMC in 26 cases.

24.112 In its 2000 Report, the PSI team expressed surprise that so few complaints about poor treatment or substandard clinical practice had been referred by screeners into the performance procedures. The PSI team carried out an analysis of the reasons given by medical screeners during the period from June to December 1999 for deciding that cases did not raise an issue of SDP. The common reason (given in 33% of cases) was that the case did not show any evidence of SDP. The second most frequent response (24% of cases) was that there was **'no pattern of poor performance'**. The third most frequently given reason was that **'the case showed only a single incident – and no pattern'**. This does not seem to have led to reconsideration of the practice whereby the GMC did not usually enquire locally about further concerns to ascertain whether any pattern did in fact exist. The 2000 PSI Report observed:

> **'... screeners ... clearly felt restricted by the requirement for a case to show a pattern of poor performance before it could be referred under the performance procedures. Since most of the cases they saw related to single incidents, and no investigation had taken place to establish whether there was a pattern of poor performance, it was not surprising that this was the conclusion they came to.'**

24.113 In 15% of cases examined by the PSI team, the reason given was that the complaint related to matters that had occurred before July 1997. It is clear, therefore, that, even two years later, the decision not to admit evidence of events before that date was still exerting an effect.

24.114 By March 2000, eight assessments had been completed. However, in 2000, the pace quickened markedly. During that year, action was initiated by the GMC in 126 cases. Twenty eight assessments were completed during that year. In 2001, action was initiated by the GMC in 70 cases and 57 performance assessments were completed. During 2002, action was initiated in 80 cases and 67 performance assessments were completed.

24.115 In November 2002, the requirement to send 'rule 5 letters' was removed. The point at which the GMC 'initiated action' was, therefore, redefined. Curiously, it was now defined as the point at which arrangements were made to set up an Assessment Panel. I say 'curiously' because the first action taken by the GMC in a case in which a screener had decided that an assessment was appropriate was to send the doctor an invitation to undergo assessment; one might have expected, therefore, that it would be the sending of that letter which would have been regarded as the initiation of action. The new definition might account for the apparent decrease in the number of cases in which action was

initiated after November 2002. However, the recent figures do suggest that the number of cases entering the performance procedures had stabilised and may even have been decreasing. In 2003, the GMC initiated action in only 42 cases and the same number of performance assessments were carried out.

Delays

24.116 By 2000, there was considerable concern both within the GMC and outside about the delays in dealing with performance cases. This was at a time when the GMC was struggling to deal with a growing backlog of cases and its FTP procedures were under great pressure generally. Within the GMC, the delays in dealing with performance cases were attributed to the pressure of work in the office. Difficulty in obtaining the necessary evidence from referring bodies was also said to be a factor. Mr Howes told the Inquiry that, by the time the GMC's performance procedures came into operation in July 1997, the GMC had been working on their development for several years. Local NHS bodies had not had the same period of preparation as the GMC and were not equipped to deal with issues of poor performance. He said that, with time, referring bodies became better and better at cataloguing the problems they were having with doctors and, as 1st July 1997 receded, they were able to relate a longer history of problems in support of their concerns.

24.117 The Performance Section's Annual Report, given to Council in May 2000, indicated that the problems of delay had been addressed by recruiting additional staff and by better liaison with referring NHS bodies. As I have said, it certainly appears that far more cases were dealt with in 2000 than previously.

Statistics Relating to the Assessment Referral Committee

24.118 The Annual Reports and annual FTP statistics also contained details about the activities of the ARC. The ARC considered seven cases between the inception of the performance procedures and 31st March 2000. In all but one of the cases, the ARC decided that the doctor should be required to undergo an assessment. In the other case (heard prior to May 1999), the ARC concluded that the evidence of potential SDP after 1st July 1997 was insufficient to justify an order that the doctor should be assessed. During 2000, the ARC received nine cases and directed that assessments should be undertaken in seven of those cases. The 2001 FTP statistics contain no information about the activities of the ARC. In 2002, 40 doctors were referred to the ARC. In 15 cases, the ARC directed a performance assessment. In 17 cases, it decided that no assessment was necessary. In a further eight cases, voluntary erasure was granted. In 2003, the ARC received 19 cases. In nine cases, the ARC directed a performance assessment. In four, it decided that no assessment was necessary. Voluntary erasure was granted in two cases and four cases were awaiting hearing at the time the statistics were compiled.

24.119 The statistics relating to hearings by the ARC reveal, first of all, that quite a large number of doctors refused to undergo performance assessments when requested to do so. This had not been anticipated when the performance procedures were introduced. Furthermore, they reveal a significant number of cases where the ARC decided not to direct that a performance assessment should take place.

24.120 Mr Marshall said that it was not for him to 'second guess' the decisions of the ARC, particularly since he was not present at most of the hearings and was not privy to the ARC's discussions. However, he observed that it was 'on the face of it surprising' that, in 2002, more cases had been closed at this stage than had proceeded for assessment. This was particularly so since the test which should have been applied by the ARC was very similar to the screening test. Mr Marshall pointed out that the ARC often had more information (particularly from the doctor) available to it than did the screeners. An uncooperative doctor might not have responded to the invitation to submit observations to the medical screener. At a hearing before the ARC, however, s/he might give evidence and arguments would be put forward on his/her behalf, usually by a legal representative. As I have already mentioned, it was not usual for a complainant (or a representative of a complainant body) to be called to give evidence before the ARC. The hearing was, therefore, likely to be a one-sided process.

Statistics Relating to Assessment Panel Reports

24.121 Up to 2001, it was unusual for an Assessment Panel report to result in a finding that a doctor was fit to practise and that no GMC action was, therefore, necessary. Miss Smith's impression was that this rarely happened. However, as I have already mentioned, the GMC FTP statistics for 2001, 2002 and 2003 show that such a finding became quite common. In 2001, 18 out of 57 (i.e. 32%) completed assessments resulted in a finding that the doctor's performance was 'acceptable'. In 2002, the figure was 14 out of 67 (i.e. 21%) of assessments. In 2003, 13 out of 42 (i.e. 31%) assessments resulted in a finding that the doctor's performance was 'acceptable'.

Statistics Relating to the Statement of Requirements

24.122 In 1999 and 2000, there were very few cases in which, following a performance assessment, a statement of requirements was agreed. Most cases were referred to the CPP. In 2001, a statement of requirements was agreed in six out of 57 cases (i.e. 11%) where a performance assessment had taken place. In 2002, the figure was eight out of 67 cases (i.e. 12%). In 2003, statements of requirements were agreed in 17 out of 42 cases (i.e. 40%).

Statistics Relating to the Committee on Professional Performance

24.123 Up to March 2000, the CPP had held five performance hearings and had in each case found the performance of the doctor to have been seriously deficient and had imposed a period of suspension of registration. In 2000, the CPP held four performance hearings. In each case, it made a finding of SDP. It imposed periods of suspension in two cases and imposed conditions on the registration of the other two doctors. In 2001, there were 23 performance hearings. In three cases, the CPP found the doctors' performance to have been 'acceptable'. In 20 cases, there was a finding of SDP. In seven cases, suspension was imposed and 13 resulted in the imposition of conditions on the doctors' registration. In 2002, there were 27 performance hearings. In nine cases, the doctor's performance was found to have been 'acceptable'. Of the remaining 18 cases, where SDP was found,

seven resulted in suspension and 11 in conditions being imposed on the doctor's registration. In 2003, out of 21 performance hearings, the CPP found the doctor's performance 'acceptable' in two. Four cases resulted in suspension and 12 in the imposition of conditions on registration. Of the remaining three, two were adjourned and one resulted in voluntary erasure.

24.124 Miss Smith told the Inquiry that she could not speculate upon why the CPP had found the doctor's performance 'acceptable' in such a significant proportion (33%) of cases during 2002. However, she said that, in her experience, there was considerable dispute at hearings about not only the original complaint but also the report of the Assessment Panel and the way the assessment had been carried out. The length of CPP hearings had increased over the years. She mentioned the recent case, to which I have referred, where the doctor had called no fewer than 36 witnesses.

Statistics Relating to Suspensions

24.125 Information provided to the Inquiry by the GMC reveals that 21 doctors were suspended from practice by the CPP between 1998 and the end of 2003. Of those 21 doctors, five have been indefinitely suspended, ten remain under suspension and two are now practising without restriction. Four have since been erased; three took voluntary erasure and one was erased for failure to respond to correspondence sent to his/her registered address.

Statistics Relating to the Making of Interim Orders in Performance Cases

24.126 During 2002, 18 cases classified as 'performance cases' were referred to the IOC. Mr Marshall pointed out that this classification was probably made retrospectively since, if a case was referred to the IOC by a medical screener at an early stage, it would not necessarily be clear at that time whether it was a conduct, a performance or a health case. The statistics show that six referrals to the IOC were made by performance case co-ordinators and one each by the ARC and the CPP. The other ten must, presumably, have been made by medical screeners. Mr Marshall told the Inquiry that he suspected that a higher percentage of performance cases than of conduct cases were referred to the IOC. The figure of 18 cases referred in 2002 represented 23% of cases referred to the performance procedures and 32% of those cases where the GMC had initiated action by writing a rule 5 letter.

Judicial Decisions on the Performance Procedures

The Case of Krippendorf

24.127 In November 2000, the Privy Council gave judgement in the case of Krippendorf v General Medical Council[6]. This was an appeal by a doctor from a determination of the CPP that the standard of her professional performance had been seriously deficient and a direction that her registration should be suspended for a period of 12 months with immediate effect.

[6] [2001] 1 WLR 1054.

24.128 From October 1996 until January 1998 (when she was suspended), Dr Manjula Krippendorf worked in the UK as a consultant in community paediatrics. She had obtained a certificate of full registration from the GMC in October 1996. Prior to that time, she had been working abroad in specialties which were different from, but related to, community paediatrics. In 1998, one of her former employers, a NHS trust, complained to the GMC about the techniques employed by Dr Krippendorf in administering BCG vaccines to 227 children during an immunisation programme in September 1997. These techniques had led, it was said, to an unusually high incidence of side effects. The same NHS trust also complained about Dr Krippendorf's role as consultant paediatrician in two potential child protection cases. The complaints gave rise to an invitation by the GMC to Dr Krippendorf to undergo a performance assessment, to which she agreed.

24.129 Delivering the judgement of the Privy Council, Sir Christopher Slade said that the performance assessment had been directed primarily at assessing Dr Krippendorf's professional competence in a number of areas of work, falling within what the Assessment Panel had perceived to have been her various job descriptions since 1997. The Assessment Panel had assessed her on the work which **'might come a community paediatrician's way'** within the post in which she had been employed at the time when the complaint against her was made. The Assessment Panel had expressed the view that community paediatrics required a knowledge of, and experience in, general and developmental paediatrics. The Assessment Panel had regarded clinical competence as essential when responsibility was taken for clinical care. The Assessment Panel had found that Dr Krippendorf did not possess the necessary knowledge and experience. They had tested her in basic life support techniques and had found that she demonstrated an inability to perform them. However, there was apparently no evidence that she had ever been required to use such techniques during the course of her work in the UK. During Phase I of the assessment, interviews had been carried out in places where Dr Krippendorf had worked, medical records had been examined and case discussions had taken place. Phase II had consisted of objective tests of paediatric knowledge and practice.

24.130 At the conclusion of the assessment, the Assessment Panel stated in its report that the standard of Dr Krippendorf's professional performance had been seriously deficient, that the standard of her professional performance as a paediatrician was likely to be improved only with full retraining in general paediatrics, as well as in any specific specialty such as community paediatrics, and that she should limit her professional practice to non-clinical work. The assessment report indicated that, even within that sphere, she required retraining.

24.131 At the hearing before the CPP, counsel for the GMC indicated that, the performance assessment having taken place, the GMC would not be relying on the original complaints made against Dr Krippendorf. At the request of Dr Krippendorf's representative, the Director of Public Health who had made the original complaint (and from whom the GMC had obtained a statement) was called to give evidence. When giving her own evidence, Dr Krippendorf admitted that, judged on the basis on which the assessment was carried out, she had not passed. She also expressed her intention to do no clinical work in the future, except in the field of public health. She accepted

that, even before working in that field, she should undergo retraining in some aspects of the work, as suggested by the Assessment Panel. She appealed the decision of the CPP on the ground that the Assessment Panel had not approached its function in the correct way.

The Judgement of the Judicial Committee of the Privy Council

24.132 The Privy Council found that the assessment report demonstrated that the Assessment Panel had made a basic error in its approach to its functions. Section 11(1) of the 1997 Performance Rules required the Assessment Panel to **'adopt such procedures as appear to them to be necessary having regard to the nature of the practitioner's work to assess the standard of his professional performance'**. This, the Privy Council pointed out, reflected the wording of section 36A of the Medical Act 1983, which indicated that it was the past professional performance – not the professional competence – of the practitioner in the work which s/he had actually been doing to which the Assessment Panel and the CPP should direct their attention.

24.133 It went on to observe that:

> **'... everything in the Rules suggests that it is the duty of the CPP and the Panel to have regard to the track record of the practitioner in the work which he has actually been doing. It is not their function to conduct an examination equivalent to that of a student's examination board. Theoretical questions are relevant only insofar as the answers may throw light on the practitioner's professional performance in the specific areas of work which he has actually been doing.'**

24.134 This had not been the approach adopted by the Assessment Panel when assessing Dr Krippendorf. Moreover, the assessment report had included no investigation of and no findings in connection with the original complaint about Dr Krippendorf's injection techniques. No explanation was given for that. The Assessment Panel had regarded the complaint merely as a 'backdrop' to its report. It considered that the complaint had triggered the setting up of the assessment, but that it had no further relevance from the perspective of the Assessment Panel. The Privy Council also observed that Dr Krippendorf had been asked many questions about her professional competence in dealing with the kind of problems that a general paediatrician might come across in the course of practice in the UK, without regard to whether she had ever had to deal with them in the course of her actual work. The judgement continued:

> **'Their Lordships would accept that on occasions questions directed to a practitioner's knowledge and clinical skills may throw light on his professional performance in work which he has actually been doing, in cases where there is reason to suspect that his performance in such work may have been seriously deficient. In their Lordships' opinion, however, the questions directed to and answered by the appellant** (*Dr Krippendorf*) **in the Portfolio were of far too extensive and detailed a nature properly to constitute part of the basis on which the Panel were entitled to reach their conclusion.'**

24.135 In reaching its decision, the CPP had stated that it had not relied on the original complaint against Dr Krippendorf, but instead had focussed on the evidence in the assessment report. As I have said, the Privy Council found that report to be flawed. The first reason for that was the fact that the Panel had failed to assess Dr Krippendorf's professional performance by reference to the work she had actually been doing since 1997. The second reason was the failure of the report to deal with the original complaint. The judgement said:

> **'Their Lordships do not go so far as to hold that in every case the complaint which triggers an assessment requires investigation by the Panel and the CPP. On the facts of the present case, however, the complaints should, in their Lordships' opinion, have been investigated because nothing related more directly to the standard of the appellant's actual professional performance over the relevant period. The failure of both the Panel and the CPP to investigate the complaints reflects their erroneous concentration on her professional competence, rather than her actual professional performance. ...**
>
> **In the context of fairness, their Lordships add that, in their opinion, in the particular circumstances of this case, fairness demanded that the appellant should be given a proper opportunity to refute, if she could, the serious complaints which directly related to her professional performance and had led to the assessment.'**

24.136 The Privy Council concluded that the CPP had misdirected itself in law in reaching its determination. It advised that the appeal should be allowed and that the determination of the CPP should be quashed.

After the Case of Krippendorf

24.137 The decision in the case of Krippendorf caused consternation at the GMC. Mr Scott told the Inquiry that he and his colleagues were 'somewhat flummoxed' to be told that the GMC should be investigating the initial complaints, rather than launching into an investigation by way of a performance assessment. Sir Donald Irvine said that the effect of the Krippendorf case was 'profoundly unsettling'. After this decision had been delivered, work on performance assessments was held back to enable some adjustments to be made. In December 2002, the Medical Act 1983 (Amendment) Order 2002 came into force. It introduced into the Medical Act 1983 a provision that **'"professional performance" includes a medical practitioner's professional competence'**. It also made clear that an assessment of a doctor's professional performance might include an assessment of a doctor's professional performance at any time prior to the assessment, as well as an assessment of the standard of his/her professional performance at the time of the assessment. It was intended that this should put paid to the problems that had arisen in Krippendorf.

The Case of Sadler

24.138 The case of Sadler v General Medical Council[7] concerned an appeal to the Privy Council by Mr Anthony Peter Sadler, a consultant in obstetrics and gynaecology, against a determination by the CPP, in July 2002, that the standard of his professional performance had been seriously deficient in the area of good operative care. The CPP imposed conditions on his registration, requiring him not to undertake any major gynaecological surgery, to undertake an appropriate remedial training and assessment programme if he wished to return to major gynaecological surgery and to notify the GMC promptly of any professional appointment that he undertook.

The Complaint

24.139 In December 1997, the Medical Director of the NHS trust responsible for the hospital where Mr Sadler worked had complained to the GMC about various matters, including a number of specific incidents which had occurred during surgery performed by Mr Sadler. These included two incidents of severe post-operative bleeding. By the time of the complaint, Mr Sadler had been suspended from his post.

The Report of the Assessment Panel

24.140 Having considered the case, the medical screener directed that Mr Sadler should be invited to undergo a performance assessment. Mr Sadler declined the invitation but the ARC directed that an assessment should take place. The Assessment Panel found that there were severe deficiencies in his obstetric and gynaecological practice, but recommended that he should undergo targeted retraining and supervision, with limited restrictions on his practice. Accordingly, the performance case co-ordinator drew up a statement of requirements with which Mr Sadler undertook to comply. After a period of delay, he embarked upon a period of retraining at a hospital in Bristol. Shortly afterwards, he began to operate under supervision. On the third day, he severed a patient's right ureter while carrying out an abdominal hysterectomy. As a result of this, his retraining placement was terminated. He was unable to obtain another placement and could not, therefore, comply with the statement of requirements. The case co-ordinator referred the case to the CPP.

24.141 The performance assessment report (which had been prepared before the decision of the Privy Council in the case of Krippendorf) did not concentrate on the five surgical cases identified in the original complaint. Instead, it relied largely on interviews, especially with staff at the hospital where the incidents had occurred. Mr Sadler had no opportunity of challenging the third party interviews during the preparation of the assessment report, as he was not given transcripts of those interviews until some time afterwards.

The Hearing before the Committee on Professional Performance

24.142 At the hearing before the CPP, evidence was called in connection with three of the surgical cases mentioned in the original complaint and also in relation to the incident which had

[7] [2003] 1 WLR 2259.

occurred during Mr Sadler's retraining placement. I shall call these four cases the 'index cases'. Evidence about the assessment report was also called. The hearing occupied 16 days. On the 15th day, the legal assessor advised the CPP that it should not rely on the contents or conclusions of the assessment report, or on anything adverse to Mr Sadler in the third party interviews. This was because the assessment report was flawed in some of the same respects as had been the assessment report in Krippendorf. In particular, it did not distinguish between past performance and competence and did not subject the index cases to close scrutiny. In addition, Mr Sadler had had no opportunity to challenge the third party interviews on which the report relied. The CPP took the legal assessor's advice and its decision, therefore, depended on the evidence relating to the index cases.

24.143 The CPP expressed its overall conclusions thus:

> **'The Committee find that in ... Cases 1, 2 and 5, and in Case A** (*i.e. the index cases*) **you did not meet the professional standard appropriate to the work you were doing. The Committee are sure that these cases disclosed deficiencies in your surgical practise** (*sic*) **and that these deficiencies, whether considered individually or cumulatively, were serious. Each of them discloses a worrying reliance upon unsafe surgical techniques which form no part of the normal practise** (*sic*) **followed at the relevant time by surgeons in this country.'**

The Judgement of the Judicial Committee of the Privy Council

24.144 Before the Judicial Committee of the Privy Council, the decision of the CPP was attacked on a number of grounds. In particular, it was submitted that index cases could not constitute a 'pattern' of seriously deficient behaviour. Reference was made to the definition of SDP contained in the publication 'When Your Professional Performance Is Questioned'. The November 1997 edition stated:

> **'''Seriously deficient performance'' is a new idea. We have defined it as ''a departure from good professional practice, whether or not it is covered by specific GMC guidance, sufficiently serious to call into question a doctor's registration''. This means that we will question your registration if we believe that you are, repeatedly or persistently, not meeting the professional standards appropriate to the work you are doing – especially if you might be putting patients at risk. This could include failure to follow the guidance in our booklet Good Medical Practice.'**

24.145 The Privy Council rejected the submission that the index cases could not constitute a pattern of behaviour which came within the definition of SDP, saying:

> **'Although in *Krippendorf* the Board did not criticise the phrase ''repeatedly or persistently'' in the GMC's guidance, it is important to bear in mind that that guidance is a generalisation seeking to cover a very wide range of professional performance. The professional demands made on a general practitioner are very different from those**

made on a consultant surgeon. A continuing failure to organise the efficient management of a general practice may (in a sufficiently bad case) amount to seriously deficient performance, but in the nature of things it must be assessed on very different evidence from that relating to shortcomings of technique in major surgery. It would plainly be contrary to the public interest if a sub-standard surgeon could not be dealt with by the CPP unless and until he had repeatedly made the same error in the course of similar operations. But as a general rule the GMC should not (and their Lordships have no reason to suppose they would) seek to aggregate a number of totally dissimilar incidents and alleged shortcomings in order to make out a case of seriously deficient performance against any practitioner.'

24.146 The Privy Council concluded that the CPP's decision was justified and recommended that the appeal be dismissed. It made the following observations on the judgement in Krippendorf:

'But without casting any doubt on the decision their Lordships feel that the distinction between competence and performance, drawn in *Krippendorf*, should not be taken too far. It is important that any assessment panel should have proper regard to the complaint or other information which originally set the assessment in motion. But in most cases there is an obvious correlation between competence and performance. Moreover the assessment panel is concerned, not only with assessing past professional performance, but also with what needs to be done to improve a practitioner's performance, both in the public interest and in the practitioner's own best interests ... The process of assessment must include forming a view as to the standard of past performance, but if it is to achieve its objectives the process must not be restricted to that sort of backward-looking exercise.'

And

'... their Lordships think it right to reiterate that the process of assessment involves not only the examination of past performance but also assessment and planning (in all but the worst cases) for improvement and rehabilitation. Many assessments and statements of requirements lead to a satisfactory outcome, and a formal hearing before the CPP proves to be unnecessary. Their Lordships do not wish to send out a message that assessment by an assessment panel should be regarded as solely, or even primarily, designed as a process of collecting evidence in order to establish a prima facie case against a practitioner. Where a formal hearing before the CPP is unavoidable parts of the assessment panel's report may still be inapposite to the determination of the first question that the CPP has to decide; but the whole report is likely to be relevant to the subsequent issue of disposal if it arises.'

The Standard of Proof

24.147 In the case of Krippendorf, the legal assessor had said when advising the CPP:

> **'The burden of proving seriously deficient performance rests on the Council throughout, as is conceded and you should not make such a finding unless you are sure on the evidence that such was the case.'**

24.148 In opening the case of Sadler to the CPP, the GMC's counsel had indicated that the appropriate standard of proof was the criminal standard of proof and that the legal assessor in Sadler had advised the CPP in appropriate terms. Before the Privy Council, counsel for the GMC did not seek to put forward a lesser standard of proof, but sought guidance on the appropriate standard of proof for future cases. In giving such guidance, the Privy Council said this:

> **'The function of the CPP is not penal. It is to protect the public and to rehabilitate (if possible) practitioners whose professional standards have fallen too low. In the first of its tasks (that is deciding whether the standard of a practitioner's performance has been seriously deficient) the CPP has to ascertain the primary facts (which in many cases may not be seriously in doubt) and then to exercise their judgment (in the case of some but not all the members of the CPP, their professional judgment as experienced doctors). In this exercise the standard of proof of the primary facts ought not, in the generality of cases, to be an issue which gives rise to much difficulty. So far as it is a material issue the standard should in their Lordships' view, in the generality of cases, be the ordinary civil standard of proof. There may be exceptional cases (probably cases in which the practitioner is fortunate to be facing the CPP rather than the Professional Conduct Committee) in which a heightened civil standard might be appropriate ...'**.

24.149 The Privy Council went on to echo what had previously been said by the Privy Council in the case of McAllister v General Medical Council[8]:

> **'In charges brought against a doctor where the events giving rise to the charges would also found serious criminal charges it may be appropriate that the onus and standards of proof should be those applicable to a criminal trial. However there will be many cases, where the charges which a doctor has to face before the committee could not be the subject of serious or any criminal charges at all. The committee is composed entirely of medical men and women learned in their profession and to require that every charge of professional misconduct has to be proved to them just as though they were a jury of laymen is, in their Lordships' view, neither necessary nor desirable. What is of prime importance is that the charge and the conduct of the proceedings should be fair to the doctor in question in all respects.'**

[8] [1993] AC 388.

24.150 The Privy Council pointed out that the passage from McAllister was not wholly apposite to a committee which must now have at least one lay member but, subject to that qualification, they observed that the passage applied still more strongly to a hearing before the CPP than to a hearing before the PCC. It should be noted that the Privy Council's remarks on standard of proof were made at a time when a finding of SDP could not result in erasure. It is possible that its view might have been different if erasure had been available, as it will be in future.

24.151 Before leaving the case of Sadler, I wish to draw attention to the position, highlighted by the facts of the case, of patients who are treated by doctors whose performance either has been found to be seriously deficient or has given rise to serious concerns and who are operating under the terms of a statement of requirements. It is not clear to me whether patients are told the full facts about the status of a doctor who is about to operate on them. In 1999, the Performance Issues Working Group (PIWG) (under the Chairmanship of Professor Hatch) was examining various issues including **'consent to treatment in cases where the treatment is to be given by a doctor receiving remedial training following a performance assessment'**. The PIWG recommended to Council that patients must be given sufficient information to enable them to give informed consent to treatment by a doctor undergoing retraining. The PIWG drafted some sample letters that might be sent to patients. At its meeting in November 1999, the GMC decided that further work should be done on these issues. It appears that no further progress has been made. In Chapter 27, I have made a recommendation about the provision to patients of information relating to doctors undergoing retraining.

The Inquiry's Examination of Cases

24.152 In addition to the cases of Krippendorf and Sadler, the Inquiry examined the files, provided by the GMC, of five cases considered by the CPP since 2000. They are useful as they illustrate a number of the difficulties the GMC has experienced in connection with the operation of the performance procedures, and they provide a basis for discussion about possible improvements in the procedures. The main problems are those of delay, the complexity of the procedures and the difficulty in arranging remediation. The cases also give rise to concern about the absence, in some cases, of any formal assessment before the doctor was allowed to resume unrestricted practice. In discussing these cases, I am anxious to preserve the anonymity of the doctors concerned. For that reason, I have not quoted the dates upon which the main events took place. However, the timespan covered by the proceedings is a matter of importance. I have therefore explained the chronology by reference to the time that elapsed from the time of the first report to the GMC.

The Cases KA 01 to KA 05

Dr KA 01

24.153 In the case of Dr KA 01, who was a single-handed GP, the PCO reported concerns about the doctor's general performance to the GMC. Clinical governance assessments had identified his performance as 'seriously deficient'. Numerous complaints about him had

been received from colleagues and patients. It was thought that prescribing errors of a serious kind were putting patients at risk of harm. The case was screened into the performance procedures and, three months after the first report, the doctor agreed to assessment. The assessment report was ready at the eight-month stage. It concluded that the doctor's performance was seriously deficient. In particular, I note that the doctor failed all three elements of Phase II. Dame Lesley Southgate told the Inquiry that a doctor cannot be performing well if s/he does not have an adequate knowledge base.

24.154 However, the assessment report expressed the view that the doctor was aware of his deficiencies and was keen to remedy them. The Assessment Panel thought remediation could be effective. It proposed a series of undertakings, which would have left the GP practising, although not alone. He was to have a mentor and was to work in various ways towards improvement of his systems of work. He was to be reassessed in 12 months' time. He agreed to the undertakings. However, the PCO was less than happy about the arrangements. It was now almost a year since the case had been referred to the GMC and its officers were very worried about the prospect of delay for another 12 months when, they said, **'every day he is doing harm'**. Very properly, the GMC case co-ordinator referred the case to the CPP.

24.155 A hearing followed; it took place 14 months after the initial complaint. The doctor's performance was found to be seriously deficient in six respects and he was made subject to conditions for two years. Essentially, the doctor was to continue in practice (although not alone) and was to become involved in a variety of remedial activities. Two of these, which were of considerable importance, involved following advice on retraining to be given by the postgraduate dean and the Clinical Governance Lead of the PCO. After the hearing, a salaried partner was employed to work in the doctor's practice. However, nine months later (23 months from the initial report), the GMC discovered that the doctor had not contacted either the postgraduate dean or the Clinical Governance Lead. The following month, the doctor was asked for an explanation for this; he said that he had thought that these persons would get in touch with him. He was sent a 'mild' letter of warning.

24.156 Just over a year later (that is three years and one month from the initial complaint), it was discovered that the doctor had not been complying with the condition that required him to accept the advice of the postgraduate dean and Clinical Governance Lead. It seems that he was referred to the IOC, which made an order suspending him from practice with immediate effect. The following month, there was a resumed hearing by the CPP, as the two years since conditions were originally imposed was about to expire. The doctor did not attend the hearing. The CPP panel received some evidence that he had co-operated in his remediation. However, it was not satisfied that his clinical practice had improved. The CPP panel decided that the doctor continued to present a risk to patient safety and that it would not be sufficient for the protection of the public to impose conditions on his registration. Therefore, the doctor's registration was suspended for a period of 12 months. At the resumed hearing, which would take place shortly before the expiry of the suspension, the doctor would be able to present evidence of steps taken to remedy his deficiencies.

Comment

24.157 This history shows that the doctor had practised for a period of three years after being reported to the GMC. Throughout that time, he had presented a risk to patient safety. The case has highlighted the need for the GMC to take some proactive steps to ensure that, at the very least, a doctor who is subject to conditions is complying with them. Even that would not be a guarantee that s/he was not practising at a seriously deficient level, but at least it would afford a degree of patient protection. Under the old FTP procedures, when a doctor accepted a voluntary statement of requirements, the GMC required a quarterly report of progress. I hope that the GMC now recognises the need for a similar arrangement to be made in cases where conditions are imposed by a committee or panel, rather than agreed voluntarily. However, I am not sure that this has been recognised, as I can see no provision for supervision in the new procedures. The GMC says, and I well understand its point, that it is not responsible for making the arrangements necessary for compliance with a doctor's conditions; that must be for the doctor him/herself. However, in the interests of patient protection, the GMC must be made aware of whether the doctor is complying because, if s/he is not, s/he should be brought back for more stringent measures to be considered. It seems to me that this case also calls into question the wisdom of imposing conditions for as long as two (or even three) years without any intermediate hearing. It might sound as though the imposition of conditions for three years is a tougher sanction than conditions for one year; but, if the effect were to be to leave the doctor to practise at a seriously deficient level for three years, the sanction would in fact be inadequate and would leave the public at risk.

Dr KA 02

24.158 A PCO reported to the GMC a wide variety of concerns about Dr KA 02, a GP. These included concerns about clinical competence and judgement, unreliability in relation to out of hours duties, poor hygiene within the surgery premises, breaches of patient confidentiality, lack of audit, failure to undertake continuing education, disregard of controlled drugs regulations and lack of insight in respect of his shortcomings. Almost a year later, the GMC invited the doctor to undergo assessment, to which he agreed. Phase I took place 14 months after the initial report. The assessment presented considerable difficulties because the doctor had left his former single-handed practice and had taken employment in another practice. This had been terminated and, at the time of the assessment, the doctor had only about 56 patients. The report of Phase I expressed many concerns about the clinical care provided. Phase II was not completed until ten months later because of the doctor's ill health. The doctor failed some aspects of the tests rather badly but his combined results were just acceptable. The assessment report was produced two and a half years after the original concerns had been reported. The Assessment Panel concluded that the doctor's performance was seriously deficient in a significant number of respects and recommended that he should not practise unsupervised until he had completed a period of defined remedial training under the guidance of a suitably trained GP. The doctor accepted the report and recommendations.

24.159 Despite the doctor's acceptance, the case was (appropriately) referred to the CPP and a hearing took place two years and eight months after the initial report. The doctor's

performance was found to be seriously deficient and conditions were imposed for 12 months. Principally, the doctor was permitted to work only under the supervision of a GP trainer in a training practice; he was not to work for a deputising service. He had to seek the advice of the postgraduate dean and was required to provide the GMC with information about his activities. As is usual with CPP cases, there was no feedback about progress; Miss Smith told the Inquiry that feedback usually came in only if things were not going well.

24.160 At the resumed hearing, three years and eight months after the initial report, the conditions were renewed for a further six months; at the next hearing, they were revoked. The CPP said that it felt that there was sufficient evidence of improvement to warrant that decision, although no further assessment had been carried out. Presumably, the CPP had received a report from the supervisor. Also, the doctor had signed an undertaking not to practise single-handed. No doubt that undertaking was given voluntarily. However, I do not see how it could be enforceable.

Comment

24.161 At the Inquiry hearings, I expressed concern that a doctor whose registration had been subject to conditions should have the conditions removed without any further formal assessment. In the case of a voluntary statement of requirements, the Rules required a second assessment before the restrictions were lifted. This was not so with conditions imposed by the CPP. In its final submissions to the Inquiry, the GMC accepted that the arrangements under the old procedures gave an appearance of inconsistency and that conditions or restrictions should not be lifted without adequate evidence that this was appropriate. I can see that, in some cases, a formal assessment might not be necessary: for example, where a doctor has worked under close supervision and there is a detailed report from his/her supervisor. However, where the supervision has been of a mentoring or advisory nature, I am concerned that the supervisor might not be in a position to provide a sufficiently detailed view of the doctor's progress to permit a safe decision to be made to remove the conditions. Also, I would have thought that, where a doctor has failed any aspect of the Phase II tests, s/he should be required to retake them and should not be free to practise without restriction unless and until the results are satisfactory.

Dr KA 03

24.162 The concerns expressed about Dr KA 03, a GP, related to a variety of problems, some of which sounded rather more like misconduct than poor performance. For example, it appeared that a large number of patients had been removed from the doctor's cervical cytology recall system and there was concern that this had been done, not for clinical reasons, but to allow the doctor to meet a particular target (which would, I think, trigger a payment). However, there were also concerns about his prescribing practices, particularly in relation to controlled drugs, and his management of repeat prescribing. It appeared that much of the clinical activity within the practice was dictated by the doctor's wife who was the practice manager. After some discussion between Mr Howes and a medical screener, it was agreed that further, more detailed, information should be

obtained. However, owing to an 'oversight', that was not done and the case went back to the medical screener seven months after the initial report. The screener decided that this was a performance case. Three months later, the doctor agreed to be assessed. Phase I took place just over a year after the initial complaint and Phase II another two months after that. The report was produced 18 months after the initial complaint. The report described the doctor's performance as unacceptable in several respects and as being a **'cause for concern'** in others. The doctor failed two of the three tests in Phase II. The Assessment Panel nonetheless considered that the doctor should be allowed to continue to practise, provided that he was supervised, that he did not take on any more patients and that there was a development plan for his re-education. Also, the doctor was to be required to improve his surgery premises. The doctor did not accept the assessment report and the case was referred to the CPP for hearing.

24.163 The CPP panel hearing took place three months after production of the assessment report. The CPP panel found that the doctor's performance was seriously deficient in several important respects. I note, with some interest, that this finding was made notwithstanding the reception of a large number of testimonials and a patients' petition in support of the doctor. I mention this because it demonstrates that patients may not be aware of deficiencies in their doctor's performance. Also, I think they are sometimes, possibly often, willing to write a letter of support without bringing all their critical faculties into play. The CPP rejected the Assessment Panel's suggestions for remediation as impracticable and suspended the doctor's registration for a year. In the meantime, it was suggested that the doctor should take the advice of the director of postgraduate education about the steps to be taken to remedy his deficiencies. A year later, the doctor was allowed to practise under conditions. He was to work in supervised practice. He was not to work for a deputising service. He could prescribe benzodiazepines and other controlled drugs only with the agreement of his supervisor. The doctor was told that, before these conditions could be lifted, he would be required to undergo reassessment or, alternatively, to show that he had passed the examination for Membership of the RCGP. Nine months later, the doctor underwent the Membership examination but failed. He also retook the Phase II tests. He scored just above the minimum in two of the three tests and narrowly failed the third. Four months later, at a hearing, the CPP received reports on the doctor's progress and stated that it was satisfied that **'the public are now sufficiently protected'** for it to remove the restrictions on registration.

Comment

24.164 This case gives rise to two matters of interest. The first raises the question of what test the CPP ought to have applied before deciding whether to remove restrictions. The Medical Act 1983 did not specify the test that should be applied at this stage. However, the jurisdiction of the GMC in performance cases was based upon 'seriously deficient' performance. Did this mean that if, on later consideration of the case of a doctor whose performance had earlier been found to be seriously deficient, it was found that his/her standard of performance had risen to just above the level of 'seriously deficient', the restrictions had to be lifted, even though his/her performance still gave rise to some concerns for patient welfare? The test apparently applied in the case of Dr KA 03 was not

the 'seriously deficient' test; it was said to be a higher test of 'sufficient protection for the public'. That seems a more sensible and satisfactory test, but whether it would withstand a legal challenge from a doctor I am not sure. In any event, I am not sure whether the CPP consciously considered what test it should apply; it may be that the panel just thought that the conditions should be lifted.

24.165 The second matter of interest is that the CPP found that the doctor had passed the higher test of 'sufficient public protection' notwithstanding his poor showing in the Phase II reassessment. These are objective tests set at a level where most doctors would pass easily. If this was the best that this doctor could do after a fairly intensive period of remediation and study for the RCGP Membership examination, it does not inspire confidence in his performance after a return to unrestricted practice. In short, this case shows that, at least in some cases, the performance procedures could only seek to lift seriously deficient doctors off the bottom rung of the performance ladder onto a rung just above that level. This is of considerable importance in the context of the revalidation of doctors, a subject to which I shall return later in this Report.

Dr KA 04

24.166 Dr KA 04 was a GP working in a deprived area and had a very large patient list. The PCO expressed concerns about him which were very serious and covered many aspects of patient care, including prescribing, clinical knowledge, record keeping, note taking, history taking, physical examination, communication skills and liaison with other agencies. It was also said that he signed blank prescriptions and gave them to his staff to write repeat prescriptions. Four months after the initial complaint, the doctor agreed to undergo assessment. However, shortly afterwards, he was taken ill and remained off work for five months. An Assessment Panel was appointed four months after that and the assessment was not completed until 15 months after the initial complaint. The doctor failed two of the Phase II tests and passed one. Production of the report took another two months. The Panel reported that the doctor's performance had been seriously deficient and that this had been inevitable because of the conditions under which he had been practising. However, the Assessment Panel was now of the view that the doctor's performance was no longer seriously deficient. It listed some respects in which the doctor's performance still gave rise to concern. The doctor did not respond when sent a copy of the report. The case co-ordinator felt that there was insufficient evidence that the doctor's performance was no longer seriously deficient and referred the case to the CPP.

24.167 The hearing took place two years and one month after the initial report. During that time, the doctor had been practising, save for the five months of his ill health. The CPP panel found the doctor's performance to have been seriously deficient. In particular it said that his record keeping was an **'impenetrable jumble'** and that, bearing in mind the extensive use made of locums within the practice, this put patients at risk. Records were not the only cause for concern; the doctor's assessment of patients' condition and his provision of investigations and treatment were unsatisfactory. The CPP panel imposed conditions on the doctor's registration for 12 months. In summary, these required him to establish relations with a mentor and the local Clinical Governance Lead and to work with them on

a programme of continuing education and remediation. He was to heed the advice of the PCO about the size of his list and about arrangements for the staffing of his practice.

24.168 Nearly six months later (i.e. two and half years after it had reported its concerns about Dr KA 04), the PCO wrote to the GMC, expressing further concerns. The letter said that there were huge gaps in the doctor's knowledge and that he seemed unable to improve. Patients were at risk. The PCO was consulting the NCAA and was taking steps to find out whether the doctor had a medical problem. Soon afterwards, the PCO exercised its new list management powers and stopped the doctor from practising as a GP. The doctor was then to work in a new specialty.

24.169 At the resumed hearing (just over three years after the initial complaint), the CPP panel considered whether to refer the doctor to the HC but decided there was insufficient evidence to do so. It considered that the doctor had made efforts to comply with his conditions but had been unable to do so owing to difficult circumstances. It imposed new conditions for a period of nine months. In essence, the doctor was to practise only under supervision and in his new specialty. At a further hearing nine months later (just under four years after the initial complaint), it appears that there was a substantial measure of agreement between the lawyers representing the doctor and those representing the GMC. This covered both the evidence and the proposed condition which was that, for a period of three years, the doctor was to practise only in his new specialty. There was no requirement for supervision or for reassessment. The CPP panel agreed to deal with the case on the basis of this agreed condition, although its members expressed some reservations about the limited nature of the evidence that the doctor was capable of practising to the necessary standard in this new specialty. Thus, Dr KA 04 was free to practise unsupervised within his new specialty for the following three years. That period has not yet expired.

Comment

24.170 I have two concerns about this case. First, the doctor was allowed to practise in his new specialty without having undergone any formal assessment of his competence or even a retake of the Phase II tests which he had previously failed. That had not been required, despite the fact that there was cause to suspect that his performance in that regard would not have improved. Second, provided that the doctor complied with the condition that he should practise only within his new specialty, it seemed likely that the restriction would be removed at the expiration of the three-year period. He would then be free to practise again in any capacity in which he could find employment. I do wonder whether the public has been adequately protected in this case.

Dr KA 05

24.171 This is the only one of the five cases examined by the Inquiry that did not relate to a GP. For that reason, I shall not describe it in any detail. It is also the only one of the five cases in which the CPP found that the doctor's performance was not seriously deficient, even though that had been the conclusion of the Assessment Panel.

24.172 Dr KA 05 was a locum orthopaedic surgeon. He had been the subject of a report from Hospital P to the GMC in the mid-1990s. It was said that he had carried out an operation particularly badly. A report by a group of 'Three Wise Men' also mentioned that he was said to upset nurses, patients and medical staff. The following year, another report was received from a patient, enclosing a letter from a different hospital (Hospital G), expressing concern about the doctor's surgical practice and also saying that his employment had been terminated because of several complaints about his attitude and behaviour. At this time, the performance procedures had not been brought into effect and the case was eventually dealt with two to three years after the first report to the GMC by a letter of advice under the Chapter XV procedures.

24.173 Some time later, a further expression of concern was received from another hospital, Hospital J. I shall refer to this as the index complaint. Its content was very similar to the previous ones. There were concerns about the complication rates and infection rates following surgery; there were also concerns about the doctor's 'attitude' and working relationships. The report mentioned that the reference that had come from a hospital at which the doctor had previously worked (Hospital B) was favourable as to his technical competence but mentioned difficulties in professional relationships. That means that there had been problems over working relationships at four different hospitals. However, the GMC had, from the outset of the performance procedures, taken the view that it could only consider matters arising since July 1997.

24.174 Following further initial enquiries, the doctor was invited to undergo assessment and he agreed. That was eight months after receipt of the index complaint. Owing to a shortage of lead assessors in orthopaedics, the assessment did not take place for another year. By that time, the doctor had moved on, not once but twice. First, he had worked at Hospital T and he suggested that two colleagues there should be interviewed by the Panel. However, when his placement came to an end and he moved back to Hospital B, he did not wish the two colleagues from Hospital T to be interviewed. The assessment took place at Hospital J and at Hospital T. Another six months passed before the report was ready and was sent to the doctor. The original complaints about infection and complication rates at Hospital J seemed to have disappeared into the background. The infection rates might have been due to a dressings technique used by the nurses, and the complications rate was not so different from that of another doctor as to allow any adverse conclusion to be drawn. Now the focus of criticism was on the doctor's poor working relationships. He was arrogant and 'talked down' to subordinates. Similar concerns were expressed by staff from Hospital T and there was also a complaint that he had taken on surgery beyond his capability despite being advised not to. The doctor had denied that there were relationship problems and claimed that, at Hospital J, he had antagonised the nurses by making justifiable criticisms of their dressings techniques. Any other complaints of that nature were, he said, unwarranted. The doctor had passed all the Phase II tests, albeit with some **'worrying gaps'** in knowledge and other concerns. The report said of the doctor that **'within well defined and ... limited areas of trauma ... and orthopaedics he is knowledgeable and technically competent'**. The assessment report concluded that the doctor was **'unsuitable for independent consultant practice'**. The case co-ordinator decided to refer the case to the CPP.

24.175 At the hearing, which occurred two and a half years after the index complaint, the CPP panel found that there was insufficient evidence for a conclusion that the doctor's performance was seriously deficient. The CPP did not give reasons for that conclusion. However, the GMC provided the Inquiry with a full transcript of the hearing so I have been able to form a view of what happened. Very briefly, it was clear that the Assessment Panel had not fully understood what was required of it and it had not complied with a number of formal requirements. It was far from clear what view it had formed about the doctor's overall performance. Second, it was clear that the evidence of surgical incompetence either was not extensive or else had not been properly investigated. It did not amount to much and the doctor was able to offer a reasonable explanation for the circumstances in which it was said he had taken on a task beyond his expertise. The doctor maintained that the complaints about personality problems were due, in effect, to prejudice against him, as a locum. None of the staff members who had spoken to the assessors about this was called to give evidence and it appears that the CPP panel felt that there was something in the doctor's explanation. It was not, of course, aware that similar complaints had been made about him some years previously, before the performance procedures came into operation.

Comment

24.176 I have given this account because I want to take the opportunity to make some observations about the conduct of this hearing which I hope will be of value for the future. My comments are not intended to imply that the CPP panel reached the wrong conclusion. My impression from reading the transcript is that the GMC was 'wrong-footed' in two respects. First, the Assessment Panel had made a number of technical mistakes in the completion of the assessment process. This allowed the doctor's counsel to make valid criticisms which to some extent discredited the GMC's case. Yet I am not sure that these technical criticisms actually had much to do with the merits of the case. They just seemed to. Plainly, it is important that assessors are properly trained and do not make technical errors. Also, the GMC did not call any of the witnesses who had made allegations about the doctor's behavioural problems; the CPP received the written assessment report and heard the live evidence of two of the assessors. I realise that it would be impracticable and highly undesirable for the GMC to call every person who had provided information to the assessors. However, not calling any of those witnesses 'live' enabled the doctor to claim that the witnesses had been biased against him without there being any opportunity for the CPP panel to judge for itself whether that was so.

24.177 Dame Lesley Southgate expressed concern to the Inquiry about the way in which the lawyers who represent doctors before the CPP can 'pick holes' in the performance assessments. She compared the assessment to a pointillist picture comprising thousands of small dots. Each statement or point in the assessment was a dot which went to make up the whole picture. If the lawyers were able to remove some of the dots in the assessment, it would lose its strength and credibility, just as the picture would become unintelligible if some of the dots of paint were removed. I understand her concern although I do not share it. Lawyers must be able to attack evidence on behalf of their clients. If all they succeed in doing is to remove a few dots, the CPP panel should still be able to see and understand

the picture. But, if the lawyers succeed in removing a whole swathe of dots, then the validity of the assessment may be undermined.

24.178 I mention these forensic difficulties because it seems to me that, under the new procedures, the GMC may have to present rather complex cases to a FTP panel. It is possible that, in future, a single hearing may have to consider allegations of misconduct and deficient performance and problems of health. If the panel is to consider cases in a holistic way, the investigation of the facts, the preparation of evidence and the management of its presentation will all become more difficult than at present. I shall return to these topics later in this Report.

Further Comments on the Five Cases

24.179 All these cases illustrate the problems of delay. The GMC has said that it recognises delay has been a problem and that, in the recent past, it provided better resources for the performance procedures. I have no reason to doubt that that was so. The Performance Procedures Working Group, which reported in April 2004 and to which I shall refer later in this Chapter, drew attention to concerns about delay and urged that further attempts should be made to reduce delays which occurred for reasons which were within the GMC's control. It seems to me that there is always likely to be an element of delay in performance cases, even with improved resources. If so, patients may be at risk from doctors whose shortcomings have been recognised locally but not yet proved to the GMC. Patients can be protected by interim measures to suspend or impose conditions on a doctor's registration and, as I have said, after 2000, the IOC made interim orders in performance cases. I note, however, that in none of the five cases examined by the Inquiry was there a referral to the IOC before the full assessment. I can see that, in the absence of hard evidence of harm to patients, the IOC might be reluctant to order interim suspension. It occurred to me that, once it has been decided that a doctor should be assessed, the sooner s/he underwent the Phase II objective assessment, the sooner the IOC would be in a position to make an informed interim decision. I take as an example the case of Dr KA 01. The PCT had expressed real concern for patient safety. The doctor carried on practising. In the event, he failed all three of the Phase II tests. Perhaps, in cases where the local organisation is concerned about patient safety, there should be a rapid referral to a Phase II centre and automatic referral to the IOC if the doctor fails any part of the test.

24.180 The case of Dr KA 01 led indirectly to a discussion at the Inquiry's seminars about the use of PCT list management powers. In that case, the PCT must have been very worried when, ten months after the CPP hearing, so little had happened. It had reported its concerns; the doctor had been assessed and the concerns had been found to be valid. Yet, two years later, the only real change was that there was an additional doctor working in the practice. It might also be said that Dr KA 01 had been made fully aware of his deficiencies. However, in other respects, nothing had happened to ensure that the doctor did not make the same kind of errors as he had been making in the past.

24.181 At the seminars, there was some discussion about whether a PCT in the position of that one should use the list management powers which it had had since 2002 to suspend

or remove a doctor from its list, in the interests of protecting patients. The view was expressed that a PCT would hesitate to do so where the GMC, the professional regulatory body, had considered the case and had decided upon a different course. The PCT would tend to defer to the GMC's view. That is understandable, particularly in a case like that of Dr KA 01, where the PCT was not even in existence when its predecessor had referred the doctor to the GMC. However, the view was expressed by several participants that PCTs should be prepared to use their own powers and to exercise their discretion if the remedies offered by the GMC appeared less than adequate. I note that, in the case of Dr KA 04, the PCO did stop a doctor from providing GP services. He had been through the GMC performance procedures and conditions had been imposed on his registration. The PCO remained worried about patient safety and used its own powers. I think that is appropriate. Parliament has provided these powers, presumably because it has recognised that local bodies sometimes have a closer view of what is going on than a national body and are better able to assess the needs of their own communities.

The Performance Procedures Review Group

24.182 In November 2002, the Fitness to Practise Policy Committee established the Performance Procedures Review Group, chaired by Dame Deirdre Hine, former Chief Medical Officer for Wales and former Chairman of the Commission for Health Improvement, to carry out a review of the performance procedures. The Review Group presented a draft report in November 2003 and its final report in April 2004. Members of the Review Group included Professor Alastair Scotland, Chief Executive and Medical Director of the NCAA, and Dame Lesley Southgate.

24.183 The final report of the Review Group noted that the GMC's performance procedures represented a **'major step forward in the modernisation of medical regulation'**. It went on:

> **'For the first time, the GMC had at its disposal reliable and internationally recognised tools to assess, fairly, consistently and accurately, the standard of a doctor's professional performance in any major branch of medicine. The achievements of the procedures as they stand are considerable.'**

24.184 It was noted that, with the introduction of the new FTP procedures, the present performance procedures would cease to exist. The remit of the Review Group was to consider whether the original objectives of the procedures needed to be amended and to make recommendations for the future consideration of performance issues and the use of the assessment instruments.

24.185 The Review Group explained that, before the introduction of the performance procedures, it had been expected that most doctors would be dealt with by way of voluntary procedures (modelled on the existing health procedures) so that the CPP would be a **'committee of last resort'**. It had been assumed that most doctors referred to the procedures would be capable of remediation and would be able to return to unrestricted

practice after a period of targeted re-education or training. It had also been assumed that doctors would be willing to undergo remediation and would agree to a voluntary statement of requirements for this purpose. Another assumption had been that most referrals would involve hospital consultants who had failed to keep up with the latest techniques, or doctors at early stages of their careers, whose problems could readily be **'nipped in the bud'**. In the event, these assumptions were not borne out once the procedures were introduced.

24.186 The Review Group considered that the most striking feature of the data which it had collected was the very small number of cases between 1998 and 2002 (15) in which a statement of requirements had been agreed. The Review Group observed that it was not clear whether this was because of a lack of cases in which a statement of requirements would have been appropriate, or because case co-ordinators had been unwilling to offer statements of requirements or because of a reluctance on the part of doctors to accept statements of requirements. However, the majority of cases went to the CPP for decision. It suggested that there was some evidence that the performance cases coming to the GMC were complicated by the doctors' reluctance to take advice or to seek help.

24.187 The Review Group drew attention to the number of cases in 2001 and 2002 in which a decision by a medical screener that a doctor should be invited to undergo a performance assessment had been overturned by the ARC. Its final report identified two possible reasons for this. First, the screening threshold might be too low, as a result of which 'weak' cases had been referred for assessment. Second, the fact that the doctor was able to give oral evidence before the ARC, it was suggested, might lead to a decision which was **'reasonable at the screening stage'** being **'rightly set aside when a fuller picture becomes clear'**. The draft report had suggested a third reason, namely that, as the complainant might not always appear at the ARC hearing, the decision might sometimes have been made not to assess a doctor in circumstances where, had the full picture been known, it would have been more appropriate to have undertaken such an assessment. Given the fact that it is not intended that the new FTP procedures should contain any equivalent of the ARC, the Review Group did not proceed to consider which of the possible explanations was the most likely. However, it might be valuable to analyse the reasons why screening decisions were overturned by the ARC. It might be that the effect of a 'one-sided hearing' (without the benefit of the complainant's evidence) tends to produce a particular result. If so, such hearings should be avoided in future.

24.188 The Review Group also referred to the increase in the length of performance hearings by the CPP. The average length of a performance hearing was two days in 1999 and over three days in 2002. The CPP panel sat for 15 days in 2000, 54 days in 2001, 120 days in 2002 and 90 days up to September 2003. The Sadler case alone took 16 days.

24.189 The Review Group referred to the part played by the GMC's FTP procedures in the wider framework for protecting patients. It highlighted a perception that the performance procedures did not provide adequate feedback to those with local responsibility for doctors. In particular, it drew attention to the fact that performance assessment reports were not made available to a doctor's employer or PCO. The Review Group criticised this approach, saying:

> **'If an assessment report reveals that a doctor has serious performance problems, it is important that the organisation responsible for managing the doctor locally should see the assessment report. It cannot be regarded as a private document between the GMC and the doctor.'**

24.190 The Review Group expressed no concluded view as to whether assessment reports should be disclosed to employers or PCOs in cases where the doctor's performance was found not to be seriously deficient, or where deficiencies which were not deemed serious enough to justify action on registration, but were nevertheless sufficient to warrant the issuing of a warning, had been disclosed. The Review Group recommended that the GMC should give further consideration to these issues. In my view, all assessment reports should be disclosed to employers and PCOs.

24.191 The Review Group also mentioned the failure of the ARC and the CPP to give reasons for decisions which went in favour of a doctor. Its draft report had observed that, even where reasons were given, they were **'too sparse to enable proper understanding of the position'**. The Review Group observed that the publication, from 1st July 2003, of CPP decisions on the GMC's website was **'a step forward'**. However, it considered that further measures needed to be taken in order to ensure effective feedback. It observed:

> **'... it is essential that the GMC gives reasons for every decision it makes on fitness to practise, including decisions not to take any action. An employer's role is made harder if no information is available to explain why apparently serious concerns have not been taken forward.'**

The GMC has accepted that recommendation and, in the recent past, it was the practice of the CPP to give reasons for all its decisions.

24.192 The Review Group referred also to the fact that hearings of the CPP were held in private, unless the doctor requested a public hearing. It expressed the view that performance hearings should normally be held in public, unless the CPP panel decided otherwise. In its draft report, the Review Group had observed that **'private hearings are not compatible with openness, transparency and accountability'**.

24.193 The Review Group went on to address the issue of evidence. The report pointed out that (unlike the situation that existed when the performance procedures were first introduced) doctors who are referred to the GMC in the future are likely to have been through some sort of local remedial process which has been deemed to have failed. The report raised the question of whether the GMC should be able to use evidence that might be available from other sources at the time of referral. Hitherto, such evidence had played little part once a decision to undertake a GMC assessment had been made. The report stated:

> **'... the intention** (*this presumably refers to an intention on the part of the GMC*) **is to move towards a model where reliable information gathered locally or by other organisations, is more systematically considered and plays a greater part in the GMC's overall investigation and assessment of a doctor's fitness to practise'**.

Such an approach would, the report pointed out, avoid duplication of time, resources and effort. It would also be consistent with a **'team approach'** to protecting patients and maintaining standards.

24.194 The Review Group suggested that potential sources of evidence which might be used by the GMC would be complaints (whether substantiated locally or not), reports of IRP hearings or Ombudsman's investigations or other such findings, results of **'routine or exceptional audits'** and reports of assessments carried out by the NCAA or equivalent bodies in other parts of the UK. Mention was also made of the fact that, in the future, assessments following the model of the NCAA might also be carried out at a local level. The Review Group referred to the distinction between the summative (i.e. pass/fail) character of the performance procedures (which, notwithstanding their emphasis on remediation, could result in suspension and would in the future have the potential to end in erasure) and the formative (i.e. educational) nature of the local performance procedures and intervention by the NCAA. The latter were aimed at remedial action. Nonetheless, the report suggested that it should be possible, where evidence was already available, to **'build'** a picture of performance in the round, making use of that evidence. The Review Group considered that any evidence used in this way must be attributable to the performance of the individual doctor (and not teams or systems), must be obtained and presented fairly, must be robust and reliable and must be used to achieve fair and consistent judgements across all the areas in 'Good Medical Practice'. In order to ensure that those criteria were fulfilled, the report suggested that:

> **'... employers and local bodies will need clear guidance (either from the GMC or through ''centres of excellence'' identified or created to disseminate best practice) about how to ensure that their processes led to evidence which meets these standards. ...**
>
> **Obviously, such a process would take time, effort and resources.'**

24.195 The Review Group considered that the **'direction of travel'** should be to move towards the use of local evidence wherever possible. Only where the local evidence was insufficient or inappropriate should the GMC use its own assessment instruments to investigate the doctor's performance further. The Review Group considered that, in the long term, it would be preferable for a single national body to undertake all assessments to defined national standards. It did not attempt to address the question of who should do this.

24.196 The report pointed out that the performance procedures had, from their inception, emphasised remediation far more than was customary in the conduct procedures. It observed:

> **'The fact that spm could lead to erasure whilst sdp could not, sent a powerful signal in its own right.'**

The Review Group observed that, when the procedures were devised:

> **'... remediation was rightly made a central theme of the policy model, both because it was desirable to achieve a professional consensus on the fledgling procedures, and because there was an almost complete**

absence of structured, local arrangements to support doctors in difficulty'.

24.197 The Review Group recognised that, in future, most doctors referred to the GMC with performance problems will have undergone a remedial process which has failed, or will be deemed to have failed. The Review Group noted that some people had suggested that the GMC should dispense entirely with any ambition to enable poor practice to be remedied and should instead focus exclusively on what action needs to be taken to protect the public. Nevertheless, the Review Group believed that there were **'sound reasons'** for the GMC to retain remediation as an aim and thus to retain the facility to offer a voluntary route for dealing with performance concerns. The report suggested that, most importantly, such a voluntary route provided an incentive for a doctor to co-operate with the process. The Review Group believed that, if the GMC simply abolished the existing voluntary procedures, the result would be that every doctor referred to the GMC with a serious performance problem would contest the process at every stage. This would involve significant cost and delay. The Review Group believed that, even if such an approach could be justified in terms of proportionality (which it believed it could not), such delay would not be in the public interest and would be an extremely ineffective use of resources.

24.198 In its draft report, the Review Group had stated that, nevertheless, **'the emphasis should always be on patient protection'**. This should be so particularly when the voluntary route was considered inappropriate and a case had been referred to a hearing. While remediation should not be ruled out, it was said that the objective of the CPP (in future, a FTP panel) should primarily be to decide what action needed to be taken to protect patients and the public in a case where a finding was made that the doctor's fitness to practise was impaired. This seemed to imply that, once remediation within the voluntary procedures had been ruled out, the focus should shift away from attempts to remediate the doctor and should, instead, be directed at removing him/her from practice either temporarily or permanently. As I shall explain later in this Chapter, this was the thrust of Mr Scott's oral evidence on this topic.

24.199 In the final report of the Review Group, the relevant passage had been modified and no longer appeared to suggest any change of focus away from remediation.

The Future

24.200 Notwithstanding the modification to which I have just referred in the final report, the work of the Review Group will be of great potential value to the GMC as it enters the era of its new FTP procedures. One of the points raised in its report and also stressed to the Inquiry by Mr Scott, Chief Executive of the GMC, is that many of the doctors who will in future be referred to the GMC on account of poor performance will already have been through some form of local assessment and attempts at remediation. At present, a doctor whose practice gives rise to cause for concern may undergo an assessment either by his/her local NHS body (along the lines of the assessment designed by the NCAA) and/or, possibly, by the NCAA itself. Following that assessment, the doctor may well undertake a programme of remediation, which may entail practising under supervision and/or

extensive contact with a postgraduate dean. If those measures fail, the doctor may well be reported to the GMC.

24.201 In the past, when a doctor was reported to the GMC, there had to be a completely new assessment. The local or NCAA assessment was not suitable as a basis for GMC performance procedures. It was not designed to withstand the kind of legal challenge which the GMC assessments had to weather. I do not say that in any sense of criticism. I was impressed by the evidence of Professor Scotland, who explained the NCAA's holistic approach to performance assessment. The NCAA recognises that the doctor may have health, personal or personality problems, or problems in his/her working environment. An assessment based on NCAA principles has three main elements: occupational health, behaviour and clinical practice. In short, the purpose of the assessment is to find out what is wrong and why, with a view to making things better. It is not designed to enable a decision to be made on objective criteria as to whether the doctor's performance is seriously deficient; nor would it, in future, provide a basis on which a FTP panel could decide whether the doctor was fit to practise.

24.202 The GMC has recognised that, for a variety of reasons, it is undesirable that a doctor should have to undergo repeated assessments. They are costly, time-consuming and very stressful. Sir Graeme Catto told the Inquiry that the GMC was currently engaged in discussions with the NCAA about the development of a single form of assessment which would suffice for all purposes. I do not know whether this will be feasible. Plainly, a single process would be preferable for many reasons, if it can be so devised as to achieve all its desired ends. I would think that a staged or modular process whereby information is gathered along the way might provide the answer. Both Sir Graeme Catto and Mr Scott said that the modular accumulation of evidence in support of a performance case was under consideration; at the time of the Inquiry's hearings, discussions were taking place with the NCAA about a common protocol for the collection of evidence and about the standardisation of performance assessments.

24.203 When performance problems first come to light, the primary aim must be to assess and rectify them at local level. I would have thought that all three elements of the NCAA assessment should be an essential feature of any process that seeks to resolve or ameliorate the doctor's problems. I have the impression that they form a better basis from which to devise remedial measures than the GMC procedures and that the GMC procedures do not lend themselves particularly well to that process. I may be wrong about that; it may be that the difficulties in devising suitable remedial measures have arisen because GMC Assessment Panels and members of CPP panels have not been expert in devising remediation, whereas NCAA advisers and postgraduates deans are. If a NCAA type of assessment might eventually form part of the evidence on which the GMC will wish to rely, it will have to be undertaken to a high standard and according to agreed protocols. It should incorporate some of the methodology of Dame Lesley Southgate's work. Assuming that such an assessment protocol could be devised, I do not think that local NHS bodies can be expected to carry out the assessment without support and advice. I am convinced of the need for the NCAA (or a body very like it) to provide such advice and support. I would think also that some expert assistance would be needed in evaluating the results and in devising appropriate remediation. Remediation must involve the

postgraduate deaneries, in liaison with the local NHS body. The deaneries have expertise in this area which a local NHS body will not have. Also, the deaneries should be encouraged to set up courses and to provide placements within practices where the necessary expertise is available for supervision and mentoring. The local NHS body should be responsible for funding the remediation and the overall supervision of the doctor's progress, to be effected through close attention to clinical governance measures. It may need to use its list management powers if the doctor is unwilling to co-operate or makes no progress with his/her remediation.

24.204 If all goes well and the doctor improves, the GMC need never become involved. But, if the remedial measures fail or if they are 'deemed to fail' because the doctor does not co-operate, then the GMC must take over and must decide whether the doctor is fit to practise. By this time, there should be a dossier of evidence on the doctor, comprising the initial assessments and reports from those involved in the doctor's remediation and supervision. Provided these records and reports are of a sufficiently high standard, I do not see why they should not form part of the evidence on which the GMC relies. However, I do not think they would be enough. I think that, at this stage, there would be a need for some objective testing of the doctor that would, of itself, withstand legal challenge. I would have thought that the existing Phase II tests would have a part to play. Whether there would have to be something more, I could not say. It seems to me that what is wanted at this stage is material that is as objective as possible. I would have thought that, if a doctor were to fail those objective tests, which might be set, for a GP, at the level of summative assessment, it would be appropriate to suspend the doctor forthwith unless and until s/he had passed those tests to a satisfactory level. If there were other concerns, as there might well be, the case would have to proceed to a FTP panel, where the GMC would have to present a mixture of factual and opinion evidence so as to provide a sufficiently clear picture of the doctor to allow an objective judgement to be made.

24.205 Dame Lesley told the Inquiry that she understood that the GMC would like to divest itself of responsibility for carrying out performance assessments. Under the modular or cumulative approach I have described, the GMC would not, in any event, be involved with the early assessments carried out by local NHS bodies. It might have to do assessments of doctors working in the private sector for whom there would be no other mechanism. It would seem to me to be sensible for the GMC to retain control over the final stage. If it does not, it would at least have to set the standards to be applied at that stage and to ensure that the procedures were quality assured. Whoever is to carry out assessments, it seems to me that there is an urgent need for a process which is very largely objective and which cannot be affected by allegations of bias or an attack on the procedures adopted by the assessment team. I would have thought that for a GP at least, summative assessment would provide a balanced examination and a standard that any GP might be expected to achieve.

24.206 Another problem which the GMC must face is that of decision-making by panels. It must decide on the standards to be applied generally when performance issues are raised. In the past, the standards to be applied were incorporated in the assessment itself. The assessment included an opinion as to whether the doctor's performance was 'seriously

deficient'. This made the CPP's task relatively straightforward. Sir Donald Irvine, who sat on some of the earliest performance cases, said that:

> **'It was a matter of hearing the evidence, of asking questions about the assessment . . . but not of actually trying to ''second guess'' the assessment.'**

Then, he said, the process became complicated, partly because of the Krippendorf case. A line of questioning developed where there was a tendency for the CPP to try to run a second assessment. It seemed that it became possible for the CPP panel to apply a lower threshold than the assessors themselves which, Sir Donald said, 'could not be right'. Dame Lesley Southgate spoke of her concern (and I sensed her frustration) at the way in which the results of assessments based upon the instruments devised by her team, which she likened to a pointillist picture, were 'picked at' by the lawyers with the result that the CPP could lose sight of the main picture and find the doctor's performance to be acceptable when, in her view, the assessment had clearly and objectively shown that it was not. The loss of a few 'points' from the assessment should not have this effect. However, if a major criticism in the assessment is shown to be unjustified, the panel might conclude that what remains is insufficient for an adverse finding. What the panel must not do is to apply different standards from those applied in the assessment.

24.207 In future, when the issue for the FTP panel is not whether SDP has been proved but whether **'fitness to practise is impaired to such a degree as to justify action on registration'**, FTP panels are going to be completely at sea unless a proper structure is provided for them. SDP was not a simple or wholly objective concept, although the use of the assessment instrument provided useful criteria. Moreover, the assessors received training, although it must be admitted that they did not always carry out the assessment as they should have done. If the present assessment instrument is no longer to be used, those criteria and the expertise of the assessors will be lost. Even assuming that a standardised format for local assessment could be introduced, it cannot contain judgements that the GMC could rely on; the FTP panel would have to use it only as a source of evidence. Members of the FTP panel will have to make their own judgements. If those judgements are to be fair, consistent and reliable, they will have to be guided by clear standards and criteria. The problem for the FTP panel may also be complicated by the inclusion of health and conduct issues. If standards and criteria are not provided, there will be unfairness to doctors and a potential failure to protect patients.

24.208 Mr Scott spoke at the Inquiry about the GMC's future attitude to attempts at remediation. He said that the **'short message'** from the GMC was now that **'remediation is still very important, but not for us'**. As I understood it, he was saying that the days were over when the GMC would impose conditions involving remediation as a form of support for the doctor or as a 'carrot' to encourage improvement. In future, that stage should be completed locally before the case reaches the GMC. The GMC should be using its power to suspend or impose conditions on a doctor more as a 'stick' to force the doctor to reform or else be struck off. That would represent a considerable change on the part of the GMC from the philosophy which has guided it in the past. Sir Donald told the Inquiry that, in the early days, the performance procedures were 'doctor-centred'. Indeed, he had seen the

CPP 'bending over backwards to save the doctor'. There was great emphasis on remediation. He did not object to that but thought that too great an emphasis on remediation could 'distort the decision about public protection'. Mr Scott's view was plainly influenced by the contents of the Performance Procedures Review Group's draft report. In view of the apparent change of view evident in the final report, it is not certain whether the GMC's attitude to remediation will change in the future.

24.209 In my view, the change of philosophy suggested in the Review Group's draft report was attractive. It should not be the function of a regulator to provide help and support; that is an important function but it should be for others. The function of a regulator should be to decide who is fit to be on the register and who is not. However, it may not be easy for the GMC to avoid involvement in remediation. Local procedures will not produce a 'perfect' set of results. Not every case referred to the GMC will warrant either suspension or erasure. Indeed, if it did, it would almost certainly mean that not enough cases were being referred to the GMC. Moreover, if local provision for support and remediation remains patchy, there will be some cases where the GMC will feel obliged to give a further opportunity for change. However, that said, it does seem to me that the change in philosophy is sensible and it is to be hoped that it will be possible to put it into effect.

24.210 At present, it is not entirely clear how cases of deficient performance will be handled when the new procedures come into force. It is apparent that the GMC has developments in mind besides the procedural changes which are about to occur. In my view, if the GMC is to continue to impose conditions aimed at remediation on the registration of a doctor whose performance has been found to be deficient to a serious degree, it must tackle the shortcomings to which I have referred in my discussion of the five case files. In particular, it must accept responsibility not for arranging the remediation itself but for ensuring that progress is being made and that the doctor is not just waiting 'in limbo' for something to happen. It must also, in my view, ensure that an adequate assessment of the doctor's performance is made before conditions are lifted and the doctor is permitted to practise unrestricted.