Memorandum

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Council

Regulating doctors
Ensuring good medical practice

To: Ben Jones

From: Code A

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Draft reactive lines to take in response to 'Face the Facts', 3 Feb 2011

Overview:
Key lines to take for each issue are included below in preparation for drafting reactive statements to the programme. These are based on the lines taken by Niall in the interview-a transcript of the interview is included in the annex.

Accusations of old boys club/ cronyism:

- Our role is to protect patients, not doctors – patient safety is at the heart of everything we do
- The idea of the GMC as an old boys club is very old-fashioned and that over the last 10 years the organisation has undergone a very profound change
- We have moved away from a system of professional self-regulation
- The GMC's Council now has an equal balance of medical and lay members and all members are clear in their purpose to protect patients and help drive up standards of conduct and practice

Shipman Inquiry recommendations:

- Following Dame Janet Smith's recommendations after the Shipman Inquiry, we made extensive reforms, in particular to our fitness to practise and governance models
- We are in the process of making further major reforms, including the introduction of revalidation - the biggest change to medical regulation in 150 years.
- We are not complacent; there's still work to do, but we are taking steps to get to where we need to be to ensure we can improve patient safety.

Decision to abolish OHPA:

- The decision not to proceed with OHPA was made by the government after a national consultation

- We will shortly be consulting on a new model of a medical practitioners tribunal which is fairer to patients and doctors
- The new tribunal service will operate separately from our investigation activity. This will have its own Chair, appointed through an independent process, who will report directly to Parliament on an annual basis.

The GMC not being open, not sharing information:

- We do release information whenever possible
- Our Freedom of Information team works extremely hard, often going far beyond their duties to provide the information requested by members of the public and others
- We provided the information asked for through Freedom of Information requests in 73% of cases last year
- Hearings are always held in public unless there a reason for not doing so – usually this is where there is an issue about the doctor's health

FTP reforms- less cases heard via public hearings:

- Our first priority must always be patient safety but we believe we can do this without necessarily subjecting both doctors, patients and their families to the ordeal of a public hearing which can be long, stressful, expensive and harrowing for everyone involved.
- The details of each case will still be published on our website and so the charges and decisions will still be public.

Hearing process is flawed/ biased/ outcome influenced by GMC:

- There is no evidence to support this claim
- Independent audits have found our procedures are high-quality and robust
- In 2009, there were 2243 decisions made by case examiners and panellists but only 5 successful appeals.
- The panels reach their decisions independently; the GMC and the defence team can present evidence to the panel who then make their decisions on that basis and without any undue influence from the GMC

Patients' complaints not being taken seriously:

- We take all complaints very seriously and take action when patient safety may be at risk
- About half of the 7000 complaints we receive are either not serious enough for us to take any action or they are not about a doctor and so those complaints are not taken forward

The GMC not doing enough to support patients:

- We have done a lot in this area- including running an award-winning Contact Centre and offering an interactive service to help patients make complaints on our website.
- We are constantly looking at how we can do more to help patients

Patients/ relatives/doctors unhappy with GMC decisions:

- The decisions are made by an independent Panel – the decisions they make are made independently of the GMC
- There will always be those who are unhappy with the outcomes of hearings, because they have not got the outcome they want or don't feel their concerns were addressed
- We are confident that our hearings are fair and transparent
- Our job is to protect patients. It isn't to provide redress.
- We do listen to and learn from the concerns of patients, their relatives and doctors

Treatment of doctors who are unwell:

- Ultimately our primary responsibility is to patients and so we may need to take action to restrict a doctor's practice when there are concerns that their health- including mental health issues or alcohol and drug addiction- could affect patient safety
- Only a small number of sick doctors are referred to the GMC each year under fitness to practise procedures. There is usually no need for GMC involvement for a sick doctor who has is seeking appropriate treatment and restricting their practice appropriately
- We do offer doctors with health issues support, including making sure that they work with a medical supervisor and that they are supported through to recovery wherever possible,

Accusations of 'non-establishment' (including BME doctors) receiving unfair treatment:

- We do not accept our procedures or the personnel involved in them are unfair to 'non-establishment' doctors or are racist
- Independent audits have found that our processes are fair to Black and Minority Ethnic doctors
- We do need to know more about why we receive more referrals from doctors trained overseas and we are doing some work at the moment about what is prompting more referrals from the NHS.

Length of time to investigate cases- Barton:

- Some cases do take a very long time and there are good reasons for this- for example we need to wait for the conclusion of any criminal investigation before beginning our own investigation.
- If there are any immediate concerns about patient safety, we hold an interim orders panel, which can restrict a doctor's practice until the case is properly heard.

Barton/ Bulstrode connection:

- Professor Bulstrode's position on Council made no difference to how Dr Barton's case was handled,as he had absolutely no involvement in her case.

Revalidation:

- Revalidation has taken too long but it is going ahead and it is our number one priority as an organisation to put in place a system so that we can be assured that all doctors on the register are up to date and fit to practise.

DRAFT reactive statement (for review after programme is broadcast)

"We were surprised/disappointed by the portrayal of the GMC as xxxxx, (which we think is out-of-date/ no longer represents the organisation etc)

"Our role is to protect patients, not doctors - that is at the heart of everything we do.

"In our view the programme did not adequately recognise the major reforms we have made to the organisation and the further changes planned. We absolutely recognise that there's still more work to do, but we have taken, and will continue to take further steps to improve patient safety."

Niall Dickson, the Chief Executive of the General Medical Council

ANNEX

Transcript from interview with Niall Dickson on 25 January 2011

JW: Now, as you well know, Mr Dickson, there's a pretty wideheld public perception that the GMC is a bit of an old boy's club looking after its own interests, have you any sympathy with that view? It's pretty widely held.

ND: I think it's a very old-fashioned view, I think the GMC for the first 120 of its life, the state decided it was going to give the profession the job of looking after itself and its own, and more or less it did that. The GMC over the last 10 years has undergone really very profound change, for example, the Council that runs the body is now 50% lay, 50% doctors, when we deal with doctors who have difficulties, complaints about doctors, the agreement at the end of that process is between two members of staff, one of whom is a doctor, and one of whom is lay, and these are people who are professionals, that is their job, doing that, bringing their clinical expertise, and their objectivity to this process.

JW: But, I mean, you talk about lay people, don't you say to the lay people on your panels, 'this is the result we'd like to see?' – how can they be, when you're giving them such a steer?

ND: well, in the sense of me saying anything to a panel, I've been here just over a year, and I've never said anything to a panel and I don't intend to do so. That's not my function. The panels operate independently, they reach their decisions based on the evidence that's put before them. We do have an influence, because we are the prosecutor, if we draw that analogy, and at the end of having presented all the evidence, having put forward all the evidence, we will put forward what we think is the appropriate sanction, punishment, if you want to use that word, it isn't the punishment, but the appropriate result in the particular case. The Panel, of course listens to representatives from the counsel who are defending the doctor who will have, obviously, a different view, then come to their view after that. So our, the point where we make our view known is in the panel room and we put forward what we want to happen in that case, and sometimes panels agree with what we say, and sometimes they don't.

JW: So, in the last 10 years, you're saying, that everything's changed. And yet, the Shipman Inquiry was damning about the GMC's culture, and said it was protecting doctors, not the public. That wasn't 10 years ago, that was 6.

ND: No, what I was referring to was, we are on a journey and the Shipman Inquiry came in at the middle of that journey, and I think that Dame Janet acknowledged that there were things going on at that time which did represent very significant change by the GMC, and I'm not an expert on the history year by year, but certainly, as an observer as I did, actually as a journalist back in 2000, I could certainly see the

changes that were happening within the GMC at that time. I would say, however, that more dramatic change over the last 5-6 years, particular with changes to our governance arrangements so that, for example, members of council are no longer involved in panels, or in considering cases, all that stuff has been professionalised.

JW: Well, you'll know then if you remember covering the piece, to quote the chair, Dame Janet Smith, 'the culture within the GMC is focussed too much on being fair to doctors, not sufficiently on the need to protect the public,' – she was damning in her verdict and that wasn't many years ago. Was she right to be so critical?

ND: I think she probably was right to be critical as she looked back, and remember she was looking back a very long way, back to the 70s, and the GMC over that whole period...but she was...

JW: But Mr Dickson...

ND: She was critical at that moment...

JW: But she was saying things had to happen, and they had to happen soon, and 6 years on, many of the things she demanded haven't happened. Many of the fundamental reform that she called for, stripping the GMC of its power to discipline doctors, has in fact been swept away, hasn't it, with the abolition of an independent regulator...

ND: I think John you've just chosen what you think is the most fundamental reform, I think the most fundamental thing that she did is ask for a review of revalidation. That, I think, was a positive move, but also, I think, it slowed down the process. I think we are, now back up and running on that and we've absolutely taken that forward and that's our number one priority as an organisation, that's to put in place a system that we can be assured that doctors are up to date and fit to practise, and that's something we've not been able to do in our 152 year history.

JW: These are so-called MOT checks for doctors?

ND: that's as good a way of putting it as any

JW: and 6 years on, they're still not in place

ND: No, indeed, but they would've been in place, not as good as we're going to do it I have to concede, had the Shipman Inquiry not come in, in effect, she put it on hold and said you've got to go back to square one. The Government then took on responsibility, said we're going to look at other professions as well as medicine, produced two green papers and a white paper, said we're going to change the regulations, that took some time in order to do that. what I don't deny is that there are bits within the profession that are quite resistant and I think again, a big journey has happened and that's really important. I think the way that doctors look at this now is certainly very different to how they did 20 years ago even 10 years ago as

well, doctors are much more willing to accept this external scrutiny, to be able to provide that assurance, because they can do more good than they've every done before, but they can also do more harm.

JW: why have they had this sort of road to Damascus experience?

ND: well I think all professional groups go through change, and they have to respond to social change around them the age of defence has gone, I think that younger doctors are much more used to that process. The profession has had quite a traumatic decade than the 1990s, and I think in the last 10 years there has been quite significant change in the way they've done it, and that is reflected in this building, people come to work and we say it again and again, we are here to protect patients. We need to be fair to doctors, but we are here to protect patients, that's what we're about and that's what Dame Janet wanted us to do.

JW: But how can you convince the public that the changes are more than cosmetic, I mean, when the GMC retains its power to adjudicate on doctors, doctors pay subscriptions to the GMC, doctors elect council members...

ND: No they don't. Doctors do not elect council members. We've got to be absolutely clear, Dame Janet did not suggest that doctors should stop paying for their own regulation, and I would absolutely resist the idea that the state takes over that role. We have independent regulation not state regulation, and I don't think that people want state-controlled doctors. On the other hand, it's not right that the profession does this on its own, and the answer is independent regulation, where we have a council that is reflects both very forceful and independent lay people but also doctors as well who have an absolutely commitment to patient protection. I think if you were to go and ask doctors what they think of us, a lot of them would think that we are too harsh. We've become too harsh in this process. I think we've got it about right, but we are going to do further reform.

JW: But you'll see that many of the public will think that, by paying their subscriptions to the GMC, it's like paying subs to your union? I pay to the union of journalists...

ND: it is anything but paying your subs to...

JW: When things go wrong I would look to it for protection – where's the difference?

ND: I think if you were to ask any doctor they would say that they understand they pay their subscription to the BMA. They are the trade union and they protect my rights. I pay my subscription – fee to the GMC and I accept that the GMC is there first to set professional standards. You've concentrated a great deal on when things go wrong with doctors, and that's fine, it's a big part of our work, but our fundamental role is setting standards for doctors. Our document GMP is used in every continent in the world. It's seen as being the best, it's copied, its' s seen as being the best for any regulatory system in the world. I'm really proud of that and I'm proud of the work

we did it in consultation working with patients and doctors about to kook at it again, it's due for a review.

The second thing we do is regulate medical education, we are responsible for the outcomes for medical schools, for the quality of doctors in this country, we are responsible for postgraduate medical education. For ensuring the specialists that treat you, the GPs who treat you, are of the highest standards. The new ones are of the highest standards in the world. These are very fundamental responsibilities. The bit when doctors go wrong, that's important too, but it's not all that we do.

JW: The image persists, I know you're here to do something about it, but it's a strong one, and I looked around one of your court rooms, that's what it reminded me of, and I think I'm the first journalist ever to have done so. Why is it so secretive? Why can't people come in here?

ND: I don't want to keep referring to the fact that I was a journalist, but as a journalist, I not infrequently I sat in these hearings

JW: that's sat observing, but when I wanted to record something, when I wanted to wander around..

ND: would you walk into the high court now and take your tape recorder? The answer is no, judicial proceedings are not normally recorded. There's nothing secret about what happens. You can go in and report what happens in our hearings. We held over 300 hearings last year and only 14 were held all in private and the reason for this is that the concerns were all about the health of the doctor. They go into private session where there are issues that are about the privacy of the doctor, otherwise they are held in public?

JW: are they? Only last week didn't you propose having more hearings in private to speed things up so more doctors won't face a public inquiry?

ND: No, just to be absolutely clear, we're not proposing that more hearings should be held in private, in fact the rules about what is held in public and private will remain the same,– and the onus is that hearings will always be held in public - what we're proposing is that if we can agree with the doctor a set of things, and perhaps one of those is that he can perhaps give up and retire and go off the register, we may be more prepared to do that without taking them through a public hearing. A public hearing means that the thing lasts longer, if they have health problems and the like it can be a very harrowing experience, it's a very harrowing experience for everyone, and for witnesses on either side of the case and it's extremely costly, both for medical defence organisations and to us. If we can still be as transparent, that is to say, I sit down with you, we have a discussion about what has happened in your case.

If we can agree that perhaps you have training, work under supervision for a while, this could be a good thing. We'll still issue a statements, as we do now, setting out what has happened

ND: There will be no cover-up…it will still be published on our website… still issue statements as we do now and publish them on our website. The result will still be public, investigations not public. We will still be held to account on are we continuing to protect the public.

JW: Staying with the business of public, when Drs make mistakes the public suffers. The Shipman Inquiry wanted more support for the public, a support service, an inquiry line they can phone – this doesn't seem to have happened?

ND: We have done a lot and are always looking at this, how to do more. We have a Contact centre that thousands of members of public use, awarded for way it treats people, the speed of answering the phone. These people are trained to deal with doctors and patients, information about how to put a complaint in about doctors. Interactive website to help people making a complaint and also about hearings, what they are likely to expect as can be a traumatic experience. There is always more than you can do, wider problem that Dame Janet made– there should be a single means by which people can make a complaint- this has not happened, has not been resolved. Obviously not a GMC only issue, various attempts at organising this complaints system – some, arguably, more complicated than others. Onus to simplify system – note, different systems in other UK countries. Current Mid-Staffs inquiry – looking at maze of complaints system that is difficult for patients. I have sat with contact centre person – absolutely help and direct people calling.

JW: One of criticisms heard about consistency of decision making, half of doctors aren't investigated by GMC. What constitutes professional misconduct?

ND: There is a definition of PM - If you seriously and persistently breach our guidance. The explain the process, around 7,000 complaints a yr, around half are not for us – often, complaint about a system fault, may not be a named doctor. Half investigation team decide they are for others to look at. Half, potentially for us to investigate. Of those, around 20% (*of the whole*) probably dealt with local level. We will write to employer, we will say we've had a complaint and give us assurance they will resolve, OR let us know if there we need to know anything else. About 30% - they are serious and we need now to investigate, we haven't investigate so far but we need to. Some – no further action to take. Some, a letter saying "don't do it again". Some, a formal warning which is something that says we don't think your competency is impaired but we will give you a warning. Doctor involved in something not hugely serious we would still not expect them to do. If doctor shows a lot of insight, and they will put systems in place to make sure they are not doing that operation again, then we will agree undertakings with them and they will go on their record and we will monitor them. Then the more serious ones if you like, or if the doctor denies the facts of the case, they're prepared for a hearing. We are like the CPS, prepare a case for the panel and the doctor prepares their case…

JW: But are you investigating enough case, is what people say? Cases recently were the GMC missed some spectacular cases altogether until it was brought to their attention.

ND: You make a good point about the limitations of a professional regulator. I'm not standing in every ward, every operating theatre, we respond to the complaints that are brought to us – but I believe modern regulation requires us to do more than that. The next step is starting to understand patterns going on around the system:

JW: So you agree, you need to and you will be investigating more?

ND: No, that's not investigating, that's understanding more what's happening and trying to prevent what is happening. There are two ways of doing it: first, I sit here and things are brought to me and I will investigate. Doesn't mean I/GMC will be standing in a ward, we have to rely on other doctors saying 'I'm not sure he's up to scratch', or other healthcare professionals or patients. This is a fundamental change - we have all this data and produced stats as Dame Janet has recommended, but we haven't analysed what data means and learned from it. For example if there is an area of practice (locums) if there were problems in that area and we saw it, we should reflect it back to the service and say you should do more. Or for doctors at the stary of their careers – are they getting the right levels of support? Need to be a learning organisation as well as just dealing with individual cases.

JW: You haven't answered the fact, there have been spectacular cases that GMC hasn't investigated, until they were almost dragged into it. For instance, Dr Barton…not most glorious hour for GMC.

ND: You're right, I am not going to comment on details of individual cases. Some cases take a v long time. There are reasons for this, not a reluctance of GMC to investigate cases. For some cases, if there are criminal investigations, we hold back as do not want to interfere with criminal process - police and CPS might be angry with us if we did this. Same with employment tribunals and coroners. Can causes anguish for doctors – open up case (had it reported to us as we have to do by law). Any immediate concerns about patient safety, hold an interim orders panel – is there a potential risk to patients, do we need to restrict a doctor until case is properly heard. Often, dealing with v serious cases, we do hold back, does delay process – makes it extremely frustrating.

JW: And potentially can lead to a dangerous doctor still practising.

ND:, No it doesn't, as I've just explained we have this Interim Orders Panel that considers is there a risk to patients here. If there is, panel will then decide the doctor can't practise…happens on a daily basis, we make decisions to restrict Dr's practise pending investigation. There is a difficulty with not immediately investigating because of criminal investigation, employment tribunal etc – there is frustration on all sides. The doctor might regard it as double jeopardy/hit with two braces at once.

But I entirely accept, not least for people who are complaining or if for example, the criminal investigation does not do anything, then it seems like an inordinate amount of time before the GMC picked it up.

Can I make one other point, which I think is really important in all this? I think there is a feeling, and I quite understand it on behalf of many patients who feel that their relatives have been damaged by doctors, that the GMC is somehow here to provide some form of redress. I have to tell you that is not our job.

Our job is to protect patients. It isn't to provide redress. There is redress within the system, within the sense of people being able to take civil action or going to the ombudsmen or all those other things. Our job is a narrower one. It is about protecting future patients and that includes of course reflecting on the reputation of the profession and the like but it isn't to punish doctors. Now, that doesn't mean that I'm going back into what you described as the Dame Janet criticism of more on the doctor's side than the patient's side. We have to be on the patient's side, we have to have patient protection as the first, second and third priority.
JW – So I have to ask you, what do you think of the decision not to strike Dr Jane Barton off the medical register when she was implicated in the death of a number of her patients at their inquests?

ND– As you know we don't comment on the detail of the cases but of course in this case, I did, rather exceptionally, make a comment at the end of that case. And what I said was that, that these were facts, that we were surprised of the decision that the Panel had made; Point 1. Secondly, that we had called the Panel and when I say 'we,' I mean counsel for the GMC, having heard all the evidence, having been in the Panel hearing, having heard all our evidence presented and heard the other side of evidence presented, we called for that doctor to be erased from the register. I said I was surprised about it and I said I would consider our position. Now there is a body, the Council for Health Regulatory Excellence, which has the job of going through every single GMC decision and deciding whether it's too lenient and whether they should appeal to the High Court. CHRE did do that with this case and concluded that there wasn't a realistic chance of appealing the decision. And there are complex reasons for that, which I won't go into, in terms of the detail of the case. But what I will say is the threshold for appeal is quite high. It has to be what no reasonable panel could've decided but I absolutely understand that people in lots of cases and of course, in this one, are not happy to say the least.

JW– But I mean the families are outraged. The families say that for more than five years, when the GMC wasn't investigating Dr Barton, the fact that her brother was a council member of the GMC wasn't declared. They say that is cronyism, that's the old boys' network, exactly the same criticisms that have always surrounded the GMC.

ND– Let me be absolutely clear about this that Christopher Bulstrode, to whom you're referring, was a council member here. He had absolutely no involvement

whatever, in any way, shape or form in the case of Jane Barton. Indeed, he didn't have any involvement in any way, shape or form in any fitness to practise cases.

JW– Surely he might've mentioned though, 'my sister is up before the GMC.' Surely he didn't mention it, he didn't declare it did he?

ND– I wasn't around at that time. My understanding of it is that we didn't know that.

JW– He didn't declare an interest and he's a member of the council?

ND– I think that it is a moot point, interestingly enough. My view would be that if we had a council member who had someone who was involved in a fitness to practise hearing, then I would expect them to say so. There is another way of looking at it, and a perfectly reasonably one, which is to say, going along to the director of fitness to practise saying, 'oh by the way, my son, my daughter or whatever is involved in your fitness to practise hearings' might be seen as attempting to influence in some way, shape or form. My view is that transparency is the right answer; you should do it.

JW– So that's not going to happen again?

ND– I can't speak for him but he may well have felt that 'this is absolutely nothing to do with me' which it wasn't and even in the wider policy area, where council does make policy, any policy changes that are made are not retrospective so the rules, the whole way which that case would be handled would not be affected by any decision that she made so again, I do understand how people might regard this outside but I have to say, I have worked in the public sector, I've worked in the private sector, I've worked in organisations like the BBC and this organisation has the highest levels of ethical standards. There is no sense of cronyism around this building, there's no sense of it being a club. All my staff come to work everyday with one objective, which is to protect patients. And it is inculcated throughout the whole organisation and it is shared by every member of our council.

JW– And yet your critics would say, when it comes to non-establishment doctors, those regarded as perhaps those regarded as a maverick or ethnic minority, or those with mental health issues, the GMC tends to come down disproportionately harder, they're more likely to be struck off, we've heard or have stringent conditions put on them. Some say so stringent, they're effectively sacked, put out of work, stigmatised so they can't work.

ND– You put a number of categories together so I'll try and deal with them separately. I think that dealing with doctors who are ill is a significant problem and its difficult trying to do it sensitively because it's very traumatic and clearly we are concerned with the potential harm that a doctor could do rather than the actual harm and that sometimes feel bad for a doctor who hasn't done anything but may have a significant mental health problem. We have independent assessments; it is not done on a whim. We have independent assessments and then if necessary, it is

considered by a Panel and then the Panel will have a doctor on it as well as lay people on it – often with a lay majority. I believe that we try and handle these cases as sensitively as we can. We continue to learn, we are talking now to organisations that represent sick doctors, and we are dealing with Action for Victims of Medical Accidents as well. All these kinds of groups to try and understand how best we deal with those issues.

The issue around ethnicity is a long standing one. The GMC was accused, many, many years ago of being disproportionately hard, as you put it. Two standards. Again, independent analysis of this says it's not true and we'll go on repeating this. We need to keep on looking at how we deal with this. The independent work by Kings College London, analysis which we commissioned from the Economic and Social Research Council and from the National Clinical Assessment Service, these are all different sources, illustrate that the problem we have in terms of performance is not related to your ethnic state, it is related to where you trained. We have a problem, which we can see with some doctors, only a tiny minority, but with some doctors, who are trained overseas and that has become confused in peoples' minds. Less so now because, from the past, many of them, would've been obviously been a different colour from doctors who were home grown. I think that there is an onus on us as a system to make sure we provide the right support for doctors who are coming to this country from others. I don't regard us moving doctors from one country to another as moving a chess piece from one bit of the board to another, it is much more like a flower that you uproot and put back down again and unless you nurture it and unless you provide that support, then that doctor can find themselves in some difficulty.

JW– But we've heard on the programme that a doctor from the EU was able to get on our register, our medical register here, without being properly tested for language or competency.

ND– That's a different issue but related but there is a real issue with doctors from the EU. The fact is that at the moment, I can, for UK doctors be pretty sure about the quality of what's coming out of medical schools as we are responsible for regulating those medical schools. We're also responsible for regulating postgraduate and medical education. We know what we're about as far as that's concerned. For doctors from overseas, not in the EU, we first of all demand a language test and secondly, we demand that those doctors sit a competency test, including, and we've a big centre up in Manchester for doing this, a practical test where they have to go through various stations, where various clinical situations are put to them and that gives us some assurance about the basic level of competence of those doctors. When it comes to doctors within the European Union, I can't language test them and I can't competency test them. They simply walk through the door. There's nothing I can do about it.

JW But what do you think about it?

ND- I think it's an outrage. It's ridiculous and we're working with the Government at the moment and I have to say this is a slow and painful process. The European Union knows that we are concerned about this issue. It's all around free movement of labour. Our argument is that doctors are not the same as tour guides. If you go along and start showing someone around London, down the wrong street, that's not a big problem but frankly, if you can't speak English and you're not competent to practise medicine and you're going from one culture to another, then you may not be safe to practise. But I, at the moment, am completely powerless; the GMC is powerless in order to do anything about that. We need to something about this.

JW– So you've got a pretty big task ahead?

ND– We have a really big task ahead but I would say overall...

JW– Which begs the question of course that there are really big problems to overcome, which is the point of our programme.

ND– Well there are, and it may seem to not be a straight word but there are obviously significant challenges. What I would say is that the nature of our work is contentious. There are bound to be people, this is not to minimise what they're saying or anything like that, but there are bound to be people who feel unhappy with the result. Because of the nature of what we do, it is likely that either a patient or doctor is going to be extremely dissatisfied with the result of what we do. It's a confrontational and contentious process. What we do is very important. And in the year and a bit that I've been here, I've inherited an organisation which is on a journey, you're right. But which, actually, the quality of the work and the quality of the people is extremely high. We will always be subject to criticism. It is possible you will be able to come back in three or four years' time and again, you will certainly find people who will say, the GMC is unfair, it didn't do my case in time and in the proper way'. That is the nature of what we do but that doesn't mean that we shouldn't be listening to what these people are saying and learning from it and we will.