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*From the Chief Executive and Registrar*

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**Chair**
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Xx June 2010

Sir Christopher Kelly KCB
Committee on Standards in Public Life
35 Great Smith Street
LONDON
SW1P 3BQ

Dear Sir Christopher

**Impact of the Ethical Framework: Survey of Regulators**

1. Thank you for your letter of 23 April 2010 inviting us to participate in your Committee's research into standards of conduct in the UK and the impact of regulation. It was also helpful to have Code A confirmation that you are interested in how we regulate and assess standards of conduct within the medical profession itself, i.e. not focusing only on the position of our Council members as office holders (appointed by the Appointments Commission which I understand has also been asked to participate in the research).

2. This response takes each of your questions in turn and briefly refers to any matters relevant to the impact of ethical standards on our governance, before then discussing issues relating to standards and ethics for the medical profession,

*Question 1: What is your role and what responsibilities do you have for upholding high standards of conduct in public life?*

3. We are the independent regulator for doctors in the UK. We trace our origins to the Medical Act 1858 which unified nineteen previous professional bodies into a single body styled 'the General Council of Medical Education and Registration of the United Kingdom'. Our current legislation, the Medical Act 1983 (as amended), sets out our purpose as being to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

4. We do this by:

   a. Controlling entry to the Medical Register and keeping the register up to date.

   b. Determining the principles and values that underpin good medical practice.

   c. Setting and monitoring the standards for medical schools and post-graduate education and training.

   d. Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

5. Our work is overseen by our Council. As recently as 2003, our Council had over one hundred members, around three-quarters of whom were medical members. This was reduced in 2003 to thirty-five, but still with a strong elected medical majority.

Comment [s1]: Say why regulatory framework and professional standards are needed? The 'buyer beware' principle isn't sufficient because of the nature of the risks; the need for patients to be able to trust doctors (para 36); public health risks if trust breaks down. (Trust, Assurance and Safety)

6. A number of scandals of the 1990s – Bristol, Alder Hey, Neal, Ledward and Shipman – revealed a common theme: while in each case individual practitioners had varying degrees of culpability for their own actions, in every one the system in which they operated was also found wanting. This led to two significant developments. First, there has been an increasing emphasis on systems regulation – notably through the work of the Care Quality Commission in England, with whom we have recently signed a Memorandum of Understanding to give formal effect to our close working relationship. And second, major reforms have been made to the basis of healthcare professional regulation, as brought together in the White Paper *Trust, Assurance and Safety: The Regulation of health professionals* (London: Department of Health, February 2007, Cm 7013). As from 2009, our Council has had 24 members, all of them appointed, and half of them medical and half lay.

7. We set out the role of Council in our Governance Handbook: 'Council is our governing body. Council is responsible for the overall control of the GMC. Council ensures that we are properly managed, and that we fulfil our statutory and charitable purposes'.

8. Our Council has formally endorsed the principles identified by the Department of Health (England) in *Implementing the White Paper Trust Assurance and Safety: Enhancing Confidence in Healthcare Professional Regulators* (June 2008) as being those which should underpin the work of councils of professional regulators, including the centrality of upholding our purpose as set by Parliament and a commitment to effective governance.

*Question 1: The impact of an ethical framework on the medical profession*

9. The Medical Act 1983 gives the GMC power to give advice to the profession on standards of standards of professional conduct; standards of professional performance; or medical ethics, as the Council thinks fit. Our advice takes the form of a list of 'duties' that apply to all doctors. These are amplified in our core guidance *Good Medical Practice* and in a number of supporting booklets and guidance notes. The advice describes good practice, rather than minimum standards, and deals, for the most part, with principles and standards that have general application. This is guidance, not rules, and doctors must use judgement to apply the guidance to the particular circumstances they face, or be prepared to explain why they have not behaved in accordance with the guidance.

10. The guidance forms the foundation of the GMC's work: it informs the undergraduate curriculum, will provide a framework for revalidation (a system for assuring that doctors are up to date and fit to practise, that is currently being developed), and the standards against which doctors are judged if complaints are made about them to the GMC. Our advice booklets explain to doctors that 'serious or persistent failures to meet the standards [in this guidance] will put your registration at risk'.

Comment [s2]: Standards are agreed by both profession and public – creates confidence that they are the right standards and a reasonable expectation to place on doctors; also transparency about what we say to doctors.

11. The GMC's guidance is sent to all doctors at the point of registration, and doctors are required to read the guidance and sign a statement agreeing to comply with it. In

addition, medical students at UK medical schools are introduced to the guidance and taught about the principles it contains; doctors are sent new guidance or updated versions of the guidance booklets as they are completed, and all the booklets and other guidance notes are available on our website and hard copies can also be obtained on request free of charge.

12. We are also doing more to bring the guidance to life by showing how it applies in practice. Our principal means of doing this is through our on-line learning materials *GMP in Action* http://www.gmc-uk.org/guidance/case_studies.asp. We are also producing other styles of cases studies and vignettes, for example to illustrate the decision-making processes which may be necessary in providing care for patients nearing the end of life. http://www.gmc-uk.org/guidance/ethical_guidance/6997.asp

*Question 2: To what extent do public office holders (in your area of responsibility) observe high standards of conduct as defined by the Seven Principles of Public Life?*

13. In its Governance Handbook, our Council has formally adopted the five principles of regulation defined by the Better Regulation Executive, and also acknowledged the good practice outlined in the *Good Governance Code for the Voluntary and Community Sector* jointly published in 2005 by a group of voluntary sector support organisations: Charity Trustee Networks, the Association of Chief Executives of Voluntary Organisations, the Institute of Chartered Secretaries and Administrators and the National Council for Voluntary Organisations, along with the Charity Commission. We also take account of the principles articulated in the *Good Governance Standard for Public Services* produced by the Independent Commission on Good Governance in Public Services (Office of Public Management and the Chartered Institute of Public Finance and Accountancy, 2004).

14. Council members are appointed by the Appointments Commission through a process of open competition against agreed role descriptions and competencies. On appointment, they agree to comply with a code of conduct, contained in our Governance Handbook. This makes explicit reference to the seven 'Nolan' principles and translates them into members' corporate and individual responsibilities, including their role as charitable trustees.

15. The code of conduct requires members 'to complete and maintain their entry in the Council Members' Register of Interests, declaring any professional, business, or personal interests which may, or might be perceived to, conflict with their responsibilities as Council members in accordance with Council's guidance'. This register of interests and conflicts of interest, which is also completed by the Chief Executive and Directors, is published on our website, and covers a long and detailed list of matters of potential concern.

16. Members have a track record of excellent compliance with these requirements, for example declaring newly acquired interests promptly and, on one occasion in 2009, resigning membership of the General Medical Council following adverse reports into another regulator of which the member in question had been the Chair.

**Comment [s3]:** What about Panellists? Panel decisions affect public confidence – risk increased if panellists appear to have conflict of interests.

*Question 2: the impact of an ethical framework on the medical profession*

17. The Duties of a Doctor, which appears in each of our booklets, forms our own version of the 'principles of public life', but with a medical focus. The 'duties' places an obligation on doctors to provide good standards of medical care[1] by (amongst other things) keeping their knowledge and skills up to date and to recognising and working within the limits of their professional competence. In view of the importance of trust in the doctor patient relationship, we also identify honesty and integrity as key components of professionalism. The principles of public life – selflessness, integrity and honesty, openness and accountability – find direct parallels in the Duties of a Doctor: http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp

18. Our core guidance booklet *Good Medical Practice* contains more detailed guidance on how these principles apply in practice, including a section on 'probity', which covers a range of issues both relating directly to the practice of medicine, and to more general issues of honesty in financial affairs, giving evidence in courts and signing certificates and other documents.

19. You ask a number of questions about whether office holders observe these standards. These are complex questions to which there are no clear-cut answers.

20. First, evidence from general surveys suggests that doctors are trusted and appreciated by the public. Doctors are consistently identified by the public as the professional group most likely to tell them the truth (see Ipsos Mori Survey *Trust in Professions)*. And other surveys on aspects of patient care or patients' experience also support the view that overwhelmingly, patients and the public are satisfied with the care they receive from the medical profession in the UK. (See surveys by DH, Picker Europe and others).

**Comment [s4]:** Complaints are a very small %age of registered population of doctors.

21. In contrast, the number of complaints about doctors has been rising over the last decade. For example, in comparing 2008 and 2009, the NHS Litigation Authority reported an 11% rise in negligence claims, the Information Centre reported a 2% rise in NHS complaints in England, and the GMC itself saw an 11% rise in complaints or enquiries about doctors' fitness to practise.

**Comment [s5]:** What about numbers going through NCAS and general NHS push to reduce numbers on long term suspension? Regulatory gap and implementing NHS appraisal systems?

22. In addition, areas of poor practice continue to be uncovered, most recently, for example in Mid Staffordshire NHS Foundation Trust, but several other reports about poor care offered to groups of patients (see, for example, Death by Indifference, the MENCAP report, followed by the Michael's Review) or types of care offered, for example the care provided to the elderly and frail at Gosport Memorial Hospital.

23. The provision of healthcare is very complex, and it is difficult to isolate factors or to reach any firm conclusions about the causes of the increase in complaints and litigation. For example, the increase in complaints could be attributed to a number of factors other than poor practice by doctors. These include: more prominent information about how to make a complaint, or more awareness of bodies that deal with complaints (we tend to receive more complaints from members of the public when the GMC is in the news, for any reason), a more litigious culture, or a more consumer oriented approach to healthcare.

**Comment [s6]:** More transparency about standards e.g. growing media comment on GMC standards.

[1] We refer explicitly to the Nolan principles in our guidance for doctors working in management roles: http://www.gmc-uk.org/guidance/ethical_guidance/management_for_doctors.asp

24. Analysing the nature and number of complaints about doctors helps an understanding of the type of misconduct that doctors commit. For example, from 1980 – 2000 there was one case involving a doctor's conviction for possessing child pornography. However in the years 2003 and 2004 there were 14 cases involving or solely regarding child pornography. This was probably because of the availability of the materials via the internet, and the possibility of tracing and prosecuting anyone buying such material on line and a police operation to catch perpetrators. However, it would probably be unwise to conclude that this showed a decline in ethical or moral standards of the profession.

25. Similar factors may be at work in other areas of complaint, and of our handling of complaints. The seriousness with which particular offences are treated may also change subtly over time. Again, to take a very broad example, until the mid 1970s the GMC routinely erased doctors found to have committed adultery (not just with patients, but with anyone). Now, of course, we do not consider doctors' sexual activity to give rise to any questions about a doctor's fitness to practise, unless it involves criminality.

26. You ask about the main issues or most significant causes of concern and the most frequent complaints or allegations we deal with. I enclose a copy of the statistics for 2009 relating to allegations made about doctors and their outcome in our fitness to practise statistics. You will see that clinical care was the area most commonly raised in allegations and in cases reaching our fitness to practise hearings. However in the more serious cases, questions relating to probity were a close second (36% and 34% respectively, chart 1.2). The picture changes again when looking at offences for which doctors were struck off the register – where non-clinical aspects of relationships with patients (including improper relationships, failure to respect patient's dignity and indecent behaviour) appear in the five most common allegations (see Table 1.8).

27. These figures and the picture they paint of doctors' behaviour is of course shaped by our disciplinary proceedings themselves. The system of regulation we use at present is based largely on exception reporting. That is, doctors are registered primarily on the basis of examinations passed, and remain on the register unless a complaint is made, or other information provided, that leads to action under our fitness to practise procedures.

**Comment [s7]:** Refer to regulatory gap identified by Donaldson etc?

28. We are now working to broaden our regulatory role to introduce the revalidation of doctors. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards. Although it is widely understood that the delivery of medical care to patients will always involve an element of risk, revalidation will help doctors, employers and the GMC to provide further assurance to patients and the public that doctors working in the UK are fit to practise.

29. Revalidation will not involve a point-in-time assessment of a doctor's knowledge and skills but will be based on a continuing evaluation of their practice in the context of their every day working environment. It will be based on local systems of annual appraisal over a five year period and will simply affirm periodically what has already been demonstrated through the appraisal process. The appraisal process will include a core module based on the standards and principles of *Good Medical Practice.*

30. As revalidation is introduced it will provide clearer evidence that doctors in the UK are practising in accordance with the ethical standards and principles set by the GMC.

**Comment [s8]:** Broaden knowledge of the standards expected (amongst managers etc) and create environment to support Drs to adhere to them (e.g. CQC inspection?)

*Question 3: What has been the impact of ethical regulation and your work on standards of conduct in public life?*

31. We believe that the GMC has a key role to play in establishing and maintaining professional values. While these values must take account doctors legal and contractual obligations, they add a dimension of compassion and caring, of equality and social justice, which are often over-looked in rules-based systems of law and contracts.

**Comment [s9]:** Worth mentioning WHWD appeal court comment?

32. However, it is difficult to find evidence of causal links between guidance and doctors' behaviour. There are a number of influences on doctors' behaviour, including their contractual obligations, incentives offered by their employing or contracting bodies; statute and common law, guidance from bodies such as NICE, and other regulators such as CQC.

33. We have been exploring ways of evaluating the impact of our guidance, and have agreed that proxy measures may provide some useful answers. For example, we are able to assess whether our guidance addresses the problems that most concern doctors through analysis of enquiries to the office, through complaints and through our extensive consultation processes. We have recently also commissioned a survey of 1,000 doctors to better understand their views of our guidance and cross check the work we already do to understand what is relevant and helpful to practising doctors. We now have 'top line' results for the survey, which indicate that a large majority (95%) of doctors are aware of the GMC's guidance, and of those who have referred to the guidance 90% found it helpful or very helpful. In addition, large percentages agreed with statements that doctors should refer to GMC guidance throughout their working lives (84%) and that the guidance was relevant to doctors' working lives (82%). Extracts from the survey results are attached – we can provide the full report when it is completed next month, if that would be helpful.

**Comment [s10]:** Website hits and downloads? Complexity of issues put to Standards? Drs go to defence bodies first?

34. The learning materials which bring our guidance to life, and to help doctors understand how the principles in our guidance should be applied in clinical practice are very positively received. Feedback from users of these learning materials indicates that many doctors find the scenarios a very helpful adjunct to the principles based guidance we publish and distribute as booklets. We intend now to conduct a more formal evaluation of our web-based materials and to explore through further research how doctors seek to resolve difficult ethical dilemmas. We will use information from this research to inform the design and content of our materials and ensure that they are accessible to doctors in ways that we know they will be likely to use them.

35. We recognise however, that other levers are needed to affect doctors' behaviours and that the influence of our guidance alone will inevitably become diluted by all the other factors that have a daily impact on doctors' practice. However, taken together, our guidance, revalidation and our fitness to practise procedures (which are themselves based on our ethical guidance) will have a significant influence on doctors' standards of conduct. We will continue to develop our evaluation tools to ensure that we understand both the impact of our work in regulation, and the other influences which might help reinforce our messages, or act as barriers to compliance with the standards and principles in our guidance.

**Comment [s11]:** Refer to growing interest from other bodies e.g Mencap, Bliss to build on GMC guidance re key messages?

*Question 4: To what extent do you believe public confidence should be the over-riding measure in assessing the success of ethical regulation?*

36. Patients need to trust doctors. Patients may need to disclose intimate information about their lives and lifestyle, including matters such as abortions and sexual health; to allow doctors to see their bodies; make them unconscious or drowsy; in some circumstances, let them into their homes. Public confidence that doctors can be trusted without question is therefore vital to the provision of good healthcare. Our guidance sets out doctors' obligation to be honest and trustworthy, to act with integrity and to respect patients' privacy and dignity. We sum this up in *Good Medical Practice* by saying 'You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession'.

37. Public confidence in the medical profession remains high and appears to be based on patients' personal experiences, rather than press reports of, for example, Harrold Shipman, or the cases involving Alder Hey Hospital or Bristol Royal Infirmary. Surveys which specifically reminded interviewees of these cases saw very small drops in confidence levels. This suggests that our focus must continue to be on the doctors' personal performance and their partnership with patients in providing good care – rather than a more general concept of 'public confidence'.

**Comment [s12]:** What about Code A and Code A - especially re child protection?

38. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. This means too that public confidence, for its own sake, is not for us the over-riding measure. So, for example, we drive up standards of clinical competence and care-giving through our setting of standards for, and quality assurance of, medical education in ways which are largely unseen by the public at large. And our purpose in dealing with doctors whose fitness to practise may be impaired is not of itself punitive or exemplary: it is about ensuring that a doctor who is not fit to practise can be assisted in regaining fitness to practise if that is possible, and can be removed from the Register as quickly as possible if it is not. [This may be a new articulation of our position on public confidence?]

**Comment [s13]:** The public may believe (rightly or wrongly) that we are doing things even if they have no direct evidence eg recent examples of ID checks and language testing.

**Comment [s14]:** There's a question about how we engage the public and build public confidence!

Yours sincerely

Niall Dickson
Chief Executive and Registrar

Code A