14:18:55 1 committees. I cannot answer that question. I think you
14:18:58 2 must ask the GMC. Statistically it was a significant drop.
14:19:03 3 DAME JANET: It was marked?
14:19:05 4 A. Yes.
14:19:05 5 MISS SWIFT: I would like to come back to the
14:19:09 6 issue of standards and criteria and thresholds which you
14:19:12 7 have touched on already, which were mentioned, as we have
14:19:16 8 seen, in the recommendations of your first report and were
14:19:19 9 a thread running through your second.
14:19:21 10 You have already mentioned the difficulty
14:19:27 11 encountered by the PPC in relation to what standards, what
14:19:32 12 thresholds should be applied and you also referred in
14:19:37 13 passing to your analysis of the screening decision forms,
14:19:42 14 the differences in outcome and the assessments of risk and
14:19:45 15 seriousness.
14:19:47 16 Is there anything you want to say about those
14:19:51 17 particularly observations that you made in relation to
14:19:54 18 difficulties in identifying appropriate standards and
14:19:58 19 thresholds?
14:19:58 20 A. I think that one of the most important reasons
14:20:02 21 for introducing the screening decision forms was that there
14:20:06 22 should be some kind of standardisation if they were
14:20:10 23 screening these cases out; in other words if the screeners
14:20:15 24 were saying that they did not amount to SPM or SDP, to give
14:20:20 25 reasons why they thought in both cases why it was not

14:20:23 1 potential SPM or potential SDP. We did a content analysis
14:20:27 2 of their reasons because this was the -- in my view, this

14:20:31 3 was something which could have been used to develop
14:20:35 4 criteria, to develop guidelines on the standards and the
14:20:41 5 thresholds which were being applied by the screeners in
14:20:45 6 deciding that a case did or did not -- well, reach the test,
14:20:50 7 whether it was potential SPM or SDP.
14:20:56 8 I think one of the most interesting things here,
14:20:59 9 the extent to which the screeners filled them in, some of
14:21:02 10 them were extraordinarily detailed and good and some of them
14:21:05 11 were very brief, but when we did the content analysis, you
14:21:12 12 did tend to get the answers of, well, it is not SPM because
14:21:16 13 it is not SPM, or: It is not SPM because it is not serious
14:21:22 14 enough, or: It is not SPM because it does not reach the
14:21:25 15 threshold of SPM, or: It is not SPM because the doctor's
14:21:29 16 treatment or behaviour was reasonable.
14:21:33 17 You can see the very subjective criteria which are
14:21:38 18 being brought by the screeners in making this decision. We
14:21:42 19 did try to encourage them to give more reasons as we were
14:21:47 20 going through, "Do tell us what is the threshold, why does
14:21:50 21 not it not reach the threshold, what criteria are you
14:21:55 22 applying", but I think it was very interesting to do that
14:21:57 23 very detailed content analysis of the reasons that they were
14:22:00 24 giving. Some of them were very, very much better than
14:22:04 25 others.

14:22:05 1 I think one of the problems that has ensued since,
14:22:07 2 what we were trying to do and what the GMC agreed with us
14:22:11 3 that the point of these forms were to avoid these great long
14:22:13 4 memos with, you know, just agreed or even with screeners
14:22:21 5 writing on a memo rather than writing on this form.

14:22:28 6 I believe that the extent to which the screening decision
14:22:34 7 forms are being used now is again rather different according
14:22:40 8 to the different screener.
14:22:42 9 DAME JANET: There is no compulsion? I suppose it
14:22:46 10 is difficult with a member of the Council to compel them to
14:22:49 11 do their job in a particular way. I suppose you might take
14:22:52 12 them off the work, but otherwise it would be difficult.
14:22:56 13 A. I cannot comment on that. I think the GMC, it
14:23:01 14 is an internal --
14:23:03 15 DAME JANET: Rather grateful for people
14:23:05 16 undertaking the work as well. There are those kinds of
14:23:07 17 difficulties that arise when you are not dealing with an
14:23:11 18 employee who can be given instructions.
14:23:14 19 A. I think so. But it would not be me but I am
14:23:17 20 sure, as far as the GMC officers are concerned, it is
14:23:21 21 obviously quite difficult to ensure --
14:23:22 22 DAME JANET: I appreciate it is not you but you,
14:23:25 23 having observed the setup, must have appreciated the
14:23:31 24 difficulties of giving instructions to Council members
14:23:37 25 compared with the way one gives instructions to an employee.

14:23:41 1 A. I am sure that is right, yes.
14:23:43 2 MISS SWIFT: If we just go to the conclusions of
14:23:47 3 your final report at _HP0207843^, you address this question
14:23:53 4 of standards, if we can just go down to the bottom of the
14:23:56 5 page. If we can go over the page _HP0207844^, after the
14:24:04 6 preliminaries, it is really the final paragraph that we can
14:24:08 7 see on the screen there. You refer back to the previous
14:24:13 8 report, no common understanding of what does and does not

14:24:16 9 constitute serious professional misconduct and you record
14:24:21 10 your recommendations there and you refer to the continuing
14:24:25 11 differences between the outcomes of cases regarding UK and
14:24:29 12 overseas qualified doctors in the fitness to practise
14:24:32 13 procedures and say that those continuing differences suggest
14:24:37 14 that such guidelines are a matter of priority and that
14:24:40 15 a close and continuing audit of decisions and outcomes, at
14:24:44 16 all stages, of the fitness to practise procedures analysed
14:24:48 17 by country of qualification of the doctor is essential.
14:24:52 18 In the various works of research that you have
14:24:55 19 done with the GMC, have you ever been able to answer the
14:25:01 20 question satisfactorily whether or not racial bias does
14:25:06 21 exist within the organisation?
14:25:07 22 A. No.
14:25:10 23 Q. Why is that, very shortly?
14:25:13 24 A. We cannot say that it does exist and we cannot
14:25:18 25 say that it does not exist. I think that it is very

14:25:20 1 difficult. When people give very limited reasons for their
14:25:28 2 decisions it is very difficult to determine what the
14:25:33 3 criteria are that are being used and how these criteria are
14:25:36 4 being applied. So it is even more difficult to say that
14:25:40 5 this is because of the nature of the complaint or the person
14:25:47 6 being complained about. It is very, very difficult to
14:25:51 7 disentangle what may also be unconscious questions of bias.
14:25:57 8 DAME JANET: I suppose the only way of doing it
14:26:01 9 would be to undertake a qualitative analysis of each and
14:26:06 10 every decision, applying your own objective criteria to the
14:26:10 11 facts, and then in any effect trying to second-guess their

14:26:15 12 decision and the reasons for it. That would be an extremely
14:26:21 13 difficult and enormously time-consuming operation, possibly
14:26:25 14 not even a very reliable one either.
14:26:27 15 A. I think that is right and I think that you
14:26:29 16 know whose objective criteria? Not mine. I think there are
14:26:35 17 certain ways in which you could do it. You could certainly
14:26:39 18 have double screening on a number of cases. The other thing
14:26:43 19 that has been suggested has been the anonymisation of cases
14:26:47 20 and this has continued right from the beginning of the study
14:26:51 21 and the studies and has come up, again, I believe, as
14:26:56 22 a recommendation of the then Racial Equality and
14:26:59 23 Discrimination Group of the GMC in January of this year but
14:27:05 24 I think one of the big problems with this is an
14:27:08 25 anonymisation is just unbelievably time-consuming. It is

14:27:13 1 like the Forth Bridge. You would be there, as you
14:27:15 2 yourselves know, and that is with Tippex because there are
14:27:18 3 so many when you have a big fat file like that and the
14:27:23 4 doctor's name might appear at any point.
14:27:26 5 DAME JANET: And there are other tell-tale signs
14:27:29 6 of origin as well besides just the name.
14:27:32 7 A. Absolutely that, but just the name itself.
14:27:33 8 You just need the name to be missed name once. We did
14:27:36 9 discuss that in the introduction to the last report and
14:27:40 10 certainly we referred to how this had been carried out in
14:27:45 11 selection of medical students and how that again was found
14:27:48 12 to be extraordinarily difficult and did not really work
14:27:51 13 particularly well.
14:27:52 14 I do think that there is something to be said for

14:27:55 15 double screening, for two people to screen. You could do it
14:27:59 16 on a random basis and then for the cases to be discussed
14:28:04 17 I think there have been many more screeners' meetings and
14:28:09 18 discussions and certainly I have been present at screeners'
14:28:13 19 training days on which anonymised cases have been discussed,
14:28:17 20 which sometimes have had very interesting results.
14:28:21 21 They have been anonymised, you know, and then
14:28:23 22 discussed in groups but the results have sometimes been
14:28:27 23 quite interesting because they are cases, they are real
14:28:30 24 cases, and you can see that somebody who actually made one
14:28:33 25 decision when they had been screening the case within the

14:28:35 1 group discussion might make a different decision. That
14:28:40 2 I found very interesting. They clearly had completely
14:28:43 3 forgotten that they had screened that case.
14:28:46 4 MISS SWIFT: You have mentioned anonymisation as
14:28:48 5 a way of perhaps guarding against bias but do not the
14:28:54 6 problems of lack of transparency, reasons and so on that you
14:28:58 7 have identified go further than just possible racial bias
14:29:02 8 but also to the issue of consistency and fairness as between
14:29:07 9 every complaint?
14:29:09 10 A. I am sure that that is right and that is why
14:29:12 11 it is very clear that it is not simply a question of -- it
14:29:18 12 cannot be asserted that every doctor is treated in the same
14:29:21 13 way by the same criteria and by the same standards at every
14:29:27 14 stage of the procedures.
14:29:28 15 Q. You have rightly referred to the consistency
14:29:33 16 being necessary for the doctor as well. I mentioned the
14:29:37 17 complainant but equally as you have indicated consistency

14:29:41 18 and fairness for the doctor as well is a very important
14:29:44 19 consideration.
14:29:45 20 When you talk about standards and criteria,
14:29:52 21 I wonder if we can just explore a little bit more what you
14:29:54 22 have in mind. We know about the Good Medical Practice and
14:30:01 23 the thoroughly laudable components of the good practice
14:30:06 24 which are set out there and that was intended to replace the
14:30:11 25 things that the doctor should not do that were in the

14:30:14 1 original Blue Book.
14:30:16 2 Do you have something in mind not to replace Good
14:30:21 3 Medical Practice but to use for this purpose, something more
14:30:26 4 like the Blue Book with gradations of seriousness and the
14:30:32 5 various thresholds and criteria to be taken into account and
14:30:37 6 that sort of thing?
14:30:38 7 A. I think it is essential. I think that Good
14:30:41 8 Medical Practice is absolutely fine for what it was intended
14:30:43 9 to be but in terms of guidelines for what might or might not
14:30:51 10 affect a doctor's registration, whether fitness to practise,
14:30:56 11 you know, I think it needs much greater structuring.
14:31:00 12 This is one of the things --
14:31:02 13 DAME JANET: On the negative side, the attractive
14:31:05 14 thing about Good Medical Practice is that it stressed the
14:31:09 15 positive aspects of medical practice and that is what it was
14:31:13 16 intended to do but where one is looking at something that
14:31:16 17 may be related in some way to a disciplinary code it can
14:31:20 18 sometimes be necessary to look on the negative side; is that
14:31:24 19 really what you are saying?
14:31:26 20 A. I think that and also I think that again,

14:31:27 21 you know, that I keep on about hierarchies but Good Medical
14:31:32 22 Practice is a mixture of things which really must not be
14:31:36 23 transgressed and which would be very serious and other
14:31:41 24 points which are, for example, being polite to your
14:31:45 25 patients. This on its own could not raise an issue which

14:31:50 1 ought to affect a doctor's registration presumably; so that
14:31:57 2 you've within Good Medical Practice a lot of different
14:32:00 3 things at different levels of seriousness for want of
14:32:05 4 a better word.
14:32:06 5 DAME JANET: Do you have in mind something aimed
14:32:09 6 solely at the profession or something that could be
14:32:13 7 understood by the general public?
14:32:16 8 A. I do not see that it is difficult to design
14:32:20 9 something which could be understood by both doctors and the
14:32:24 10 general public. What I think is very important in terms of
14:32:26 11 more detailed guidance for those making decisions is,
14:32:29 12 as I have said before, examples of different types of cases
14:32:33 13 which might reach different thresholds. Again, I come back
14:32:37 14 all the time to the hierarchy of seriousness.
14:32:39 15 DAME JANET: I suppose in the course of your work
14:32:42 16 you might have come across, as I have in a different
14:32:45 17 jurisdiction, disciplinary codes in industry.
14:32:50 18 A. Yes.
14:32:50 19 Q. Where serious misconduct, gross misconduct,
14:32:57 20 conduct that might lead to dismissal, conduct that might
14:33:01 21 lead to a final warning, written warning, oral warnings;
14:33:04 22 examples are set out and, of course, there has to be
14:33:08 23 a caveat that the list is not complete.

14:33:11 24 A. Yes, but I think --

14:33:12 25 DAME JANET: That is the kind of thing --

14:33:13 1 A. This is the kind of thing that I am thinking

14:33:17 2 in terms of. The Blue Book was a bit discursive but at

14:33:22 3 least it was useful. I think that --

14:33:26 4 DAME JANET: You think we need both really that

14:33:30 5 Good Medical Practice should be there as an exhortation to

14:33:34 6 good practice but the disciplinary code, as it were, in

14:33:37 7 inverted commas should be there for what is bad and showing

14:33:41 8 how bad it is.

14:33:41 9 A. Yes, and with examples. I think, you know, it

14:33:45 10 would be helpful.

14:33:47 11 MISS SWIFT: Of course, there is to be a new

14:33:52 12 definition to enable the GMC to act on registration and the

14:33:58 13 question that the case examiners, the Investigation

14:34:04 14 Committee, are going to have to ask is whether there is

14:34:07 15 a reasonable prospect of establishing impairment of fitness

14:34:14 16 to practise to a degree justifying action on registration.

14:34:19 17 I think I have that more or less right.

14:34:19 18 A. I think it is a realistic prospect.

14:34:22 19 Q. I think that the three types of impairment

14:34:26 20 would be in relation to misconduct, deficient performance

14:34:29 21 and adverse health.

14:34:31 22 First of all, in general, how helpful do you find

14:34:36 23 that definition?

14:34:37 24 A. I think one of the problems with definitions

14:34:43 25 is the question of how you operationalise it. I think

14:34:48 1 definitions may be okay, as far as they go, and there have
14:34:51 2 been many attempts at defining serious professional
14:34:54 3 misconduct, for example, over the years, but sometimes when
14:34:59 4 you get into the specificity of it you may find it quite
14:35:06 5 difficult to say how a doctor's fitness to practise is
14:35:14 6 impaired to a degree justifying action on registration.
14:35:18 7 That is perfectly all right but give us specific examples.
14:35:20 8 DAME JANET: It is circular, is it not? "You are
14:35:25 9 in danger of being erased if your conduct is bad enough to
14:35:29 10 call into question the need to erase you."
14:35:34 11 A. There is a danger of it appearing to be
14:35:37 12 circular, yes.
14:35:38 13 DAME JANET: It may be that conduct or matters
14:35:47 14 that impair your fitness to practise is rather like an
14:35:50 15 elephant and easier to recognise than to describe but is it
14:35:55 16 your view that some efforts should be made to describe it.
14:36:00 17 I think it is your view?
14:36:01 18 A. I think in itself it might be okay but that it
14:36:05 19 needs --
14:36:05 20 DAME JANET: Exemplifying.
14:36:07 21 A. I think it needs examples given, yes.
14:36:11 22 MISS SWIFT: One of the effects of the definition
14:36:14 23 appears to be to invite the person deciding whether action
14:36:19 24 comes within the definition to focus on the appropriate
14:36:22 25 sanction at a time when perhaps they ought to be looking at

14:36:27 1 the behaviour rather than the appropriate sanction; in other
14:36:32 2 words, perhaps looking at sentence, the appropriate
14:36:35 3 sentence, before deciding whether a criminal offence has
14:36:38 4 been committed. It may be that it is a lawyer's point
14:36:42 5 rather a health professionals or health academic's but does
14:36:46 6 that seem to you to import any problems.
14:36:49 7 A. I think that is what the test is and that is
14:36:54 8 what the test has been agreed to be. I think though that
14:37:00 9 the form -- and I have been helping on the construction of
14:37:04 10 the form or advising on the construction of the form so that
14:37:07 11 it is not too unwieldy but, of course, in doing that it
14:37:11 12 throws up a lot of questions on the criteria and on the
14:37:15 13 level of seriousness and in what direction things ought to
14:37:18 14 go, having reached certain levels of seriousness.
14:37:21 15 DAME JANET: If you had a blank piece of paper
14:37, :24 16 would you start off with that definition yourself?
14:37:27 17 A. I think that is a very difficult question to
14:37:29 18 put to me or for me to answer.
14:37:33 19 MISS SWIFT: I do not want to press you further
14:37:36 20 than you feel comfortable in going, Professor Allen, but one
14:37:42 21 problem which might be perceived with the definition is the
14:37:46 22 fact that it focuses on the doctor rather than on patient
14:37:53 23 safety and so, for example, one might have a test where the
14:37:58 24 question was -- and I appreciate you may have to have more
14:38:02 25 than one question but the question included -- whether the

14:38:06 1 doctor posed an actual or potential risk to patients;
14:38:11 2 therefore, looking at the matter from perhaps a slightly
14:38:13 3 different viewpoint.

14:38:14 4 Do you think there would be any value in doing
14:38:18 5 that?
14:38:20 6 A. The present form does not actually discuss
14:38:26 7 risk to patients. I think that risk to patients could be
14:38:36 8 a question which could be added. I do not know it
14:38:39 9 necessarily has to be added to the definition.
14:38:42 10 Q. What I wondered was whether, if that formed
14:38:47 11 part of the definition, there might be less of a temptation
14:38:51 12 which you have already identified on the various committees
14:38:54 13 who considered these things to focus on matters such as
14:39:00 14 rehabilitation of the doctor, mitigating features brought on
14:39:04 15 behalf of the doctor, the doctor's apology or insight and
14:39:08 16 might instead encourage the committees to look from the
14:39:14 17 patient's viewpoint. Do you think there would be any value
14:39:18 18 in that?
14:39:18 19 A. I think ... I am sure there is value in that.
14:39:24 20 The question I find very difficult to answer is the extent
14:39:27 21 to which this ought to be put into the test which is whether
14:39:32 22 there is a realistic prospect of establishing that
14:39:35 23 a doctor's fitness to practise is impaired to a degree in
14:39:39 24 justifying action on registration,because you could argue
14:39:43 25 that implicit in that is all the things you are looking at,

14:39:47 1 level of seriousness, risk and so on.
14:39:49 2 I find it very difficult to talk about the
14:39:52 3 definition which has been agreed. I think one can get over
14:40:00 4 some of the questions that you are asking by asking further
14:40:03 5 questions relating to risk and seriousness and a patient's
14:40:09 6 perspective.

14:40:09 7 Q. You would see those as forming part of the
14:40:14 8 standards and criteria and threshold that you have
14:40:15 9 mentioned?
14:40:16 10 A. I think that that is right but I find it very
14:40:18 11 difficult to comment on the wording of the test which has
14:40:22 12 been agreed and I feel that that is a bit outside my --
14:40:31 13 DAME JANET: Your scope?
14:40:31 14 A. That's right.
14:40:31 15 MISS SWIFT: You mentioned a moment ago that
14:40:34 16 you've done some work on the case examiner decision form.
14:40:38 17 A. Yes.
15:25:56 18 Q. If we can just go to what I think is the
14:40:42 19 latest version of this. It has been provided by the GMC it
14:40:45 20 is at _HP0208707^. In fact, there are two separate
14:40:50 21 documents and I will just ask you their separate functions
14:40:54 22 in a moment.
14:40:54 23 Do you recognise this form?
14:40:56 24 A. Yes. I have been advising on this.
14:41:01 25 Q. I wonder if you could just briefly talk us

10:10:25 1 and PSI worked together to try -- and obviously the officers
10:10:31 2 as well were enormously important in this, that we worked
10:10:34 3 together to try to devise a tool which could be used by both
10:10:39 4 the GMC and for data collection purposes.
10:10:42 5 Q. Thank you. That was no digression, Professor.
10:10:49 6 A. The answer to your question is yes.
10:10:51 7 Q. In paragraph 10, merely to assist
10:10:54 8 Madam Chairman, the advice from counsel is to be found at
10:11:00 9 _HP0201484^ and particularly _HP0201485^ and following.
10:11:08 10 That is the advice given by Mark Shaw QC and Robert
10:11:13 11 Englehart endorsed by Burton J with the change of the

10:11:18 12 definite article to the indefinite article and vice versa.
10:11:21 13 That was advice concerning the very broad mesh of the
10:11:27 14 screening test.
10:11:32 15 Further down the page, paragraph 12, we can see
10:11:38 16 that the changes were introduced in the two phases which you
10:11:40 17 have touched on in your evidence: the gathering of further
10:11:47 18 information about complaints before they were submitted for
10:11:50 19 screening from September 1998 and from March 1999 screening
10:11:55 20 processes based on the screening forms.
10:11:58 21 If we go over the page _CD0500674^, I will not go
10:12:07 22 through paragraphs 13 and 14 (although they are obviously
10:12:09 23 important) because you have covered much of the ground, but
10:12:13 24 the conclusion that is set out there was that:
10:12:15 25 "The effect of these changes had been to reduce

11:15:58 1 the screen a moment ago _CD0500566^ we can see at the bottom
11:16:12 2 there again there was the reference to the change of
11:16:17 3 practice in July 2000 in relation to comments on complaint
11:16:22 4 copying a copy to the complainants. So there is another
11:16:25 5 reference there.
11:16:25 6 The other reference is that Professor Allen is
11:16:29 7 quite right that she had seen the first section of the
11:16:32 8 screening decision form yesterday and the reference is at
11:16:36 9 page 17, line 15 reference.
11:16:40 10 Further examined by MISS SWIFT
11:16:40 11 Q. Professor Allen, there is just one matter
11:16:42 12 I would like to ask you about. It cropped up yesterday when
11:16:45 13 you were answering questions from Mr Lissack. You referred
11:16:50 14 briefly in answering a question to concerns about the
11:16:56 15 changing constitution of the panels, by which I understood
11:17:03 16 you to mean the future Fitness to Practise Panels but you

11:17:07 17 may have been referring to the past and the present as
11:17:11 18 opposed to the future and I wonder if there is anything more
11:17:15 19 you would like to say about that matter?
11:17:16 20 A. I think it was the past and the present I was
11:17:20 21 referring to because I am not altogether certain about the
11:17:24 22 future composition, but certainly you do find it
11:17:26 23 extraordinarily difficult to maintain consistency when you
11:17:29 24 have constantly changing panels. Again, this is building up
11:17:34 25 the corporate memory, if you like, but it is also -- it is

11:17:39 1 very difficult to say what would or might have happened if
11:17:42 2 a different panel had been hearing various or considering
11:17:46 3 various cases.
11:17:47 4 I do stress again this question of the expertise
11:17:52 5 which was brought to the party, as it were, and how this
11:17:58 6 could very much -- everything could hinge on what a doctor
11:18:04 7 on the panel who had very strong views and who was from the
11:18:09 8 same specialty as the doctor who was being complained about
11:18:15 9 how this could almost override any expert evidence which had
11:18:22 10 been furnished perhaps in defence of this particular doctor.
11:18:27 11 DAME JANET: This is in the PPC?
11:18:29 12 A. This was in the PPC and clearly I mean, I do
11:18:32 13 not know what happens in the PCC but I can imagine the same
11:18:37 14 type of thing might happen, but what I am concerned about
11:18:39 15 is -- it was a point that Dame Janet made -- that if you are
11:18:43 16 doing something all the time you do develop a certain
11:18:46 17 expertise, whereas if you have constantly changing members
11:18:50 18 of panels or tribunals or whatever that you may not be
11:18:56 19 bringing the same standards and criteria to the panel and

11:19:01 20 you may get different results.
11:19:06 21 DAME JANET: It can be difficult enough to be
11:19:10 22 consistent in decision making when you are doing it all day
11:19:13 23 and every day and if you are not it must be well nigh
11:19:20 24 impossible, I would think.
11:19:23 25 A. I think it makes it more difficult and you can

11:19:27 1 train and you can train and you can give examples but this
11:19:30 2 is also a very expensive and a very time-consuming exercise.
11:19:36 3 MISS SWIFT: Thank you very much, indeed,
11:19:41 4 Professor Allen. That is all I want to ask.
11:19:42 5 DAME JANET: Thank you very much, Professor Allen,
11:19:45 6 for coming. I am really most grateful to you and I do hope
11:19:49 7 you have not found the additional questions that you were
11:19:52 8 not bargaining for too exhausting but I am most grateful.
11:19:57 9 Thank you very much.
11:19:58 10 Miss Swift, it is 11.20 which is a little early
11:20:03 11 for our mid-morning break but would it be more convenient
11:20:06 12 for you to take a break now and then go through?
11:20:09 13 MISS SWIFT: I think it would be, Madam Chairman.
11:20:10 14 DAME JANET: 11.35.
11:20:12 15 (11.20 am)
11:20:24 16 (Short Adjournment)
11:20:25 17 (11.35 am)
11:38:05 18 MISS SWIFT: Madam Chairman, I call Dr Arun Midha.
11:40:44 19 There is to be no broadcasting of his evidence and I will be
11:40:48 20 asking for the screens to be switched off at some points.
11:41:04 21 ARUN DANIEL MIDHA, sworn
11:41:10 22 Examined by MISS SWIFT

11:41:11 23 Q. Are you comfortably settled there?

11:41:26 24 A. Yes, thank you.

11:41:27 25 Q. Could you give your full name, please?

13:04:40 1 lunch break, no surprises there -- 1.40. It just gives us

13:04:47 2 a little over half an hour. I am concerned that we should

13:04:50 3 finish really before 3.30 if possible. That is not to say

13:04:59 4 that interested parties must not ask their questions beyond

13:05:02 5 that time but that is what I would like to aim for as

13:05:05 6 a closing time.

13:05:06 7 (1.05 pm)

13:05:19 8 (Luncheon Adjournment)

13:05:19 9 (1.40 pm)

13:05:19 10 MISS SWIFT: Dr Midha, I wonder if I could just go

13:42:45 11 to the question of standards and guidance and thresholds and

13:42:50 12 criteria. I think that you may be aware that Professor

13:42:56 13 Allen in her reports, including her latest report of this

13:43:01 14 year, has emphasised what she perceives to be a need for

13:43:06 15 clear standards, criteria and thresholds to be applied in

13:43:11 16 particular in relation to the seriousness of any particular

13:43:17 17 allegation.

13:43:18 18 You will, no doubt, be aware that the background

13:43:23 19 to that is that during the course of her work she did

13:43:27 20 observe wide variations in the perceptions of risk and

13:43:33 21 seriousness and of the outcomes between different medical

13:43:36 22 screeners and she was also concerned that different

13:43:39 23 individuals and different committees may be applying

13:43:43 24 different criteria. I think you are aware of those

13:43:46 25 concerns.

13:43:46 1 A. Hmm.
13:43:46 2 Q. Indeed, if we might just look at a portion
13:43:55 3 from her most recent report at _HP0207837^, this relates
13:44:06 4 back to as late as 2001. If we go from the fourth paragraph
13:44:13 5 down, just scroll down, it is the paragraph beginning:
13:44:16 6 "The analysis of screeners..."
13:44:20 7 She says that the analysis of screeners' decisions
13:44:23 8 in 1999/2001 showed a complex picture and she refers to the
13:44:31 9 fact that the proportion of doctors sent by screeners to the
13:44:34 10 PPC was 25 per cent, 1999; 22 per cent, 2000; 21 per cent,
13:44:39 11 2001. More evidence of hawks and doves in general with two
13:44:45 12 screeners sending an average of 30 per cent of doctors to
13:44:49 13 the PPC while two others sent an average of less than 20 per
13:44:54 14 cent, although referral to performance procedures was much
13:44:57 15 more standard.
13:44:58 16 Then she referred to the position as between UK
13:45:02 17 and overseas qualifiers which showed what she said was
13:45:07 18 a complex pattern. Halfway down that second paragraph she
13:45:11 19 refers to the fact that:
13:45:12 20 "Some hawks sent higher proportions of overseas
13:45:16 21 qualifiers but so did some doves and the reverse was true.
13:45:20 22 In other words screeners were not applying their high or low
13:45:24 23 referral rates irrespective of country of qualification as
13:45:27 24 screeners had in earlier years and although the average
13:45:30 25 ratio of UK to overseas qualifiers sent to the PPC was

13:45:34 1 roughly 2 to 3, some screeners had a ratio of almost 1 to 1,

13:45:40 2 whilst others had a ratio of 1 to 3."
13:45:45 3 Then she goes on to say that it is difficult
13:45:48 4 to comment further because she did not know whether there
13:45:51 5 were differences in the severity of cases or whether there
13:45:54 6 were other factors at play but she did observe that if the
13:46:00 7 distribution of cases to screeners was completely random it
13:46:03 8 appeared that there was evidence of a lack of common
13:46:06 9 standards applied by screeners in their assessment of cases.
13:46:09 10 Then she refers again to different assessments of
13:46:12 11 seriousness and it says that must be whether they are
13:46:18 12 applying different criteria to certain types of cases which
13:46:21 13 could lead to differences between them in their referral
13:46:24 14 rates of UK and overseas qualifiers.
13:46:27 15 That brings matters as nearly up-to-date as we can
13:46:33 16 get in relation to the published material on differences
13:46:36 17 between screeners. Do you see the screening decisions of
13:46:45 18 all the various medical screeners who are currently in place
13:46:48 19 at the GMC?
13:46:49 20 A. I see examples of all, in a sense, because it
13:46:53 21 is random so you really just receive what is sent to you.
13:46:57 22 Q. But I think at one stage -- and it may be
13:47:01 23 before your time -- different lay screeners would work in
13:47:07 24 tandem with a particular medical screener or screeners.
13:47:11 25 Does that not operate now?

13:47:12 1 A. Well it does not operate now, no.
13:47:15 2 Q. So that you will see examples of all the
13:47:19 3 various medical screeners at one time or another?
13:47:21 4 A. Yes.

13:47:21 5 Q. Have you observed variations in the types of
13:47:27 6 cases that they will send forward or, of course, in fact,
13:47:32 7 you are seeing the other side of the coin, actually variety
13:47:36 8 in the sort of standards in the sort of cases they will
13:47:39 9 close as between screeners even?
13:47:40 10 A. Your first point it is one of the criticisms
13:47:43 11 of the present system is that lay screeners do not get the
13:47:46 12 opportunity to see cases that have been sent forward, in
13:47:49 13 a sense. It would be a very good audit issue and
13:47:53 14 a benchmark, in a sense, so that is the first point I would
13:47:57 15 like to make, a slight criticism of the current system --
13:48:00 16 Q. You only see one side of the type of work --
13:48:00 17 A. -- only one side, that's right and I forget
13:48:03 18 your second question.
13:48:04 19 Q. The second was whether, even to the limited
13:48:07 20 extent that you do see the cases, you do see a difference or
13:48:12 21 an apparent difference in the thresholds being applied by
13:48:16 22 different screeners.
13:48:18 23 A. The difficulty is I could say anecdotally in
13:48:22 24 the sense I cannot measure it, you know, I do see a slight
13:48:27 25 variance in terms of how somebody would perceive what is

13:48:31 1 serious, et cetera, but it's unscientific if I say that
13:48:38 2 screener would --
13:48:39 3 DAME JANET: But you do notice, do you, from time
13:48:41 4 to time a difference in attitude.
13:48:44 5 A. Yes, occasionally. You can see an occasional
13:48:48 6 one but part of the lay screener's opportunity is actually
13:48:51 7 a corrective measure in a sense.

13:48:55 8 MISS SWIFT: I assume that you have been aware of
13:48:59 9 the tenor of Professor Allen's findings and of the
13:49:03 10 variations that she found.
13:49:04 11 A. Yes.
13:49:05 12 Q. What seems to you to be the answer to that?
13:49:09 13 A. Whilst the research was very interesting I did
13:49:16 14 feel that the conclusions drawn were limited in the sense
13:49:21 15 that it did not actually contextualise where overseas
13:49:26 16 qualifiers were actually working, the type of training they
13:49:29 17 received, I do not recollect seeing in any of her research
13:49:34 18 issues to do with how many overseas qualifiers were actually
13:49:37 19 working as locum consultants within the NHS and then the
13:49:43 20 related issue of how locum consultants are treated within
13:49:46 21 the NHS in terms of isolation, not being integrated into the
13:49:53 22 NHS structures in terms of consultant teams, et cetera,
13:49:56 23 which might impact on issues to do with the GMC.
13:50:01 24 So whilst I found the research very interesting,
13:50:04 25 I felt it was slightly limited in that it did not actually

13:50:08 1 bring in a number of compounding factors which I would have
13:50:12 2 thought would have been very useful in terms of, again, is
13:50:17 3 it as simple as overseas qualifiers being screened
13:50:22 4 differently or do you need to actually look at what type of
13:50:26 5 overseas qualifier was being screened? Was there
13:50:30 6 a preponderance of locums, for example, and then have an
13:50:35 7 insight into what is it like to operate as a locum
13:50:39 8 consultant, not understanding the subtleties of the UK NHS
13:50:44 9 system.
13:50:44 10 Q. I think there are two points there, of course,

13:50:47 11 Dr Midha. First of all, of course, you are completely
13:50:51 12 correct that the research does not answer those questions
13:50:54 13 and does not set out to answer them. I suppose that what
13:50:59 14 might be said and I think what Professor Allen was saying
13:51:01 15 was that if the distribution of cases to screeners was
13:51:05 16 completely random, then one would expect that so would the
13:51:14 17 numbers of locum consultants of doctors with particular
13:51:17 18 difficulties coming to each screener and, therefore, one
13:51:21 19 would expect the ratios to be the same, not the individual
13:51:25 20 cases but the ratios?
13:51:26 21 A. I accept your point.
13:51:27 22 Q. Leaving aside the issue of racial bias, which
13:51:31 23 obviously although it is the purpose of the research is not
13:51:35 24 the Inquiry's subject, perhaps if we just look at the top of
13:51:41 25 the screen where we have a finding that, leaving aside any

13:51:46 1 question of place of qualification, two screeners were
13:51:51 2 sending an average of 30 per cent of doctors they screened,
13:51:55 3 two others sending an average of less then 20 per cent. Of
13:52:00 4 course, that is added on to the more specific findings that
13:52:02 5 she made in her second report as to different perceptions.
13:52:06 6 Just assuming for a moment that there are
13:52:10 7 different perceptions and we obviously do not know what has
13:52:13 8 happened since 2001, how in your view could that be dealt
13:52:21 9 with? I appreciate we will be looking at case examiners in
13:52:24 10 the future but the same problem may well arise. How is one
13:52:28 11 going to solve that problem or go towards solving it?
13:52:32 12 A. I think if there is a problem you could solve
13:52:38 13 it in terms of specific training of individual case

13:52:42 14 examiners now or screeners to train people in these issues.
13:52:48 15 We did try a pilot in terms of actually anonymising cases to
13:52:52 16 see whether that would, when you actually block out any
13:52:58 17 reference to an individual's country of origin or where they
13:53:01 18 qualified, et cetera.
13:53:03 19 Q. That is not going to help, though, in
13:53:08 20 ascertaining seriousness is it, it is a different point
13:53:11 21 really.
13:53:12 22 You say training. Of course, as we have seen,
13:53:16 23 Professor Allen suggests that there is a need for clear
13:53:22 24 standards, criteria and thresholds which would no doubt be
13:53:26 25 used as a basis of training. Do you agree that there is

13:53:30 1 a need for those things?
13:53:32 2 A. I think in terms of clear guidelines, yes.
13:53:37 3 I think that there is a need to understand what the
13:53:42 4 particular threshold is for -- are we talking about the new
13:53:47 5 system of case examiners or the existing system of --
13:53:51 6 Q. Well, either really, but I suppose looking
13:53:51 7 forward --
13:53:51 8 DAME JANET: Somebody is going to have to decide
13:53:55 9 whether a case crosses a threshold, whether it is under the
13:53:58 10 new or the old.
13:54:00 11 A. I think we come back to the point of trying to
13:54:03 12 identify seriousness, which sounds easy to do but difficult
13:54:05 13 in practice and I think that I do not use the term
13:54:09 14 "training" glibly. I think that by getting more of
13:54:13 15 a corporate feel to it in terms of the new system of case
13:54:16 16 examiners if they build up some sort of -- I think Professor

13:54:21 17 Allen used this -- it is not a corporate memory, in a sense
13:54:25 18 but --
13:54:25 19 MISS SWIFT: Experience?
13:54:26 20 A. Experience possibly, rather like the
13:54:29 21 magistrates, in a sense, that you have thousands of
13:54:32 22 magistrates that there is a collective wisdom that develops
13:54:34 23 where you have guidelines which are interpretable as well.
13:54:40 24 So there are guidelines given but there is a sufficient
13:54:44 25 degree of flexibility, in a sense, because I come back to

13:54:47 1 the point that it is easier said than done to define what is
13:54:50 2 serious, purely as an issue.
13:54:57 3 Q. At the moment you have already referred to
13:55:01 4 Good Medical Practice and the benefits of that publication
13:55:05 5 but at the moment you have on the one hand Good Medical
13:55:09 6 Practice and a member of the public may get hold of Good
13:55:14 7 Medical Practice and see all the things which the doctor
13:55:17 8 should provide, but it is emphatically not the case, is it,
13:55:23 9 that a breach of Good Medical Practice of itself is going to
13:55:27 10 amount to necessarily to serious professional misconduct?
13:55:31 11 A. No, no.
13:55:31 12 Q. Do you think there would be a value in having
13:55:37 13 some form of document setting out in relation to every
13:55:45 14 category in Good Medical Practice those features which might
13:55:50 15 be aggravating features which might tend to push a case
13:55:54 16 towards serious, for example, so that a member of the public
13:55:59 17 could see that it is not just as simple as looking at
13:56:02 18 a particular point in Good Medical Practice, but there are
13:56:06 19 things that would make it more serious, things that perhaps

13:56:08 20 would make the conduct less serious?
13:56:11 21 A. I can see that working in terms I can see the
13:56:13 22 magistrate situation where you have that opportunity --
13:56:16 23 DAME JANET: We have that in law, do we not, as
13:56:20 24 you will know, for example, with the guidelines on
13:56:23 25 sentencing in burglary where you look at the aggravating

13:56:28 1 features and they are all set out in guidelines cases.
13:56:31 2 A. I am attracted to that idea, in the sense,
13:56:34 3 that --
13:56:34 4 DAME JANET: Do you see any reason why it should
13:56:38 5 not be applied?
13:56:39 6 A. In terms of -- the slight concern I would have
13:56:43 7 in terms of when you go back to being too specific when we
13:56:45 8 have mentioned issues of dishonesty where you can see
13:56:47 9 variations of dishonesty is dishonesty but it does not reach
13:56:52 10 the threshold of seriousness because of the type of
13:56:54 11 dishonesty but I take your point about identifying certain
13:57:02 12 areas but, in a sense, we do that on one of the STS forms by
13:57:06 13 definition, where you put indecent assault or rape, et
13:57:10 14 cetera.
13:57:11 15 DAME JANET: Yes, but even within those offences
13:57:16 16 themselves, you, as a Magistrate, will be familiar with
13:57:19 17 guideline cases where the aggravating or mitigating features
13:57:24 18 are listed and you are reminded of them.
13:57:27 19 A. Yes.
13:57:29 20 DAME JANET: That is really all it is, a reminder,
13:57:31 21 is it not?
13:57:31 22 A. Yes, and that does help and I have not thought

13:57:34 23 through in a sense at the PPC level, at the PCC level that
13:57:38 24 that will be a useful aid as well to have that sort of
13:57:46 25 opportunity to be able to mitigate, et cetera.

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Mr Bob Nicholls

1 which we do not need to go into.
2 I would just like to ask you about criteria
3 because one of the aspects that she considered was criteria
, 4 and the Committee's consideration of criteria and, as she
5 saw it, confusion about criteria. Do you want to comment on
6 that at all?
7 A. I think only to say, Miss Swift, that the
8 judicial reviews, her report and the aide-memoire and this
9 process I have just described of having to give reasons, did
10 make us focus on the criteria. I think I would still argue
11 that the fact that it was a panel, usually of five or even
12 more, was intended to get judgment and you have to balance
13 that with if you have two set criteria what is the point of
14 having discussions to weigh people's opinion. I think as we
15 move to the new procedures I would like to see much more
16 criteria-based decision processes which can then be
17 monitored and quality assured.
18 So I think we improved but probably not far enough
19 in terms of: was there a checklist? I think that is what
20 she was after in terms of, "Have you considered this? Have
21 you considered that?" I think in our mindset and with
22 a reasonably consistent number of panel members who worked
23 together and I referred to the statistics before the break
24 we actually did achieve more consistently than her earlier
25 reports would have suggested the PPC was achieving.

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But could I point to set criteria not sufficiently: in our minds, in the way we conducted our decision-making process, yes; helped by the aide-memoire I have already referred, Madam Chairman, to this definition of what the threshold, what would constitute serious professional misconduct and the criteria of not examining evidence, not taking sides about the evidence but was there sufficient evidence for this case to have a real prospect of being proven?

So in some ways, I think the number of criteria that we regularly refer to in all the complex cases, if she observed us again I would like to think she would actually say, "It is apparent they were using more consistent criteria, were we were recording it? Were we capturing the data about it? No", and I think that is something for the new procedures to get right.

MISS SWIFT: I think that her constant call for the setting out of standards, criteria, thresholds goes rather further than just the order in which decisions are made and questions which must be asked.

As I understand her evidence, what she would like to see is some form of agreed standards as to what sort of behaviour will or will not amount to serious professional misconduct, to take the current definition. I appreciate that that will change. Obviously there is not a black and

white answer to that because it may depend on circumstances but again the thrust of her evidence is I think that she would like to see something like a list of considerations of factors that would make conduct more or less serious.

DAME JANET: There are possible analogies that one might draw from. One is the kind of factor that the Court of Appeal Criminal Division will draw attention to in sentencing a particular type of case, "These are the aggravating factors; these are the mitigating factors". The other analogy that was mentioned to Professor Allen was the kind of list that one commonly sees in a disciplinary code in industry where you have the kinds of conduct that will or might warrant dismissal or final warning, or written warning, or an oral warning; in other words a hierarchy of seriousness. Of course, it can never be complete but it gives you a framework against which to make your comparisons.

A. I think we should learn from other bodies. I think that is an excellent idea that we should be seeing what other people do because we are going to have to with the new procedures, which is about the more generic impairment of fitness to practise, which the aim is to delegate it to these trained and selected against competencies examiners. They will need guidelines. I think I do believe that judgments come in and if

we are not to have check lists and we are not to go back to actually, "If you do that, off with your head and if you do that, you are all right" and you are asking for peer and lay

review in the investigation prosecution side of how judgment should come in. The use of guidelines what might and I think I gave answers before, it indicated that for the PPC there were certain offences that it was quite clear that, if provable, they would amount --

DAME JANET: Yes.

A. So can we orchestrate that? Can we document that in a way that will enable the Investigation Committee in the future to delegate to the case examiners and, more importantly, be able to capture data, was that followed and, if not, give a reason why you did not follow it, which would then enable quality assurance of the process to be much stronger than was done to me or my Committee in my time.

DAME JANET: There is another aspect of this and it is presentation of the GMC to the public because it seems to me that in order to command the confidence of the public, the GMC has to explain more and better what they are doing and why and that can take place in two ways. In one way by explaining their individual decisions and their reasons for them better than they do at the moment but also setting out their frameworks more clearly so that the public understands what they are doing and why.

A. Yes, and I think suggestions at the time about the future changes which are out to consultation, detailed rules and guidance being drawn up is actually extremely -- would be extremely timely here and I take the point about public perception about it, Madam Chairman.

The Good Medical Practice is very understandable,

even to me as a lay person, and does set out the positive what we are aiming for, what on the fitness to practise side we are looking at the negatives, how far have you fallen below the standard? And some colleges have actually done --
DAME JANET: The general practitioners.
A. The general practitioners: this is a good doctor; this is a bad doctor.
I think my concern is you take out the judgment of that process if that becomes too mechanistic so it is a balance. I can exactly see the need to be more transparent about what we are judging on, both for external purposes, your point, and for internal purposes, which was mine, about are we doing this well and right, are we getting this right, which we could not answer Professor Allen's report still because we did not have that data.
MISS SWIFT: Just on Good Medical Practice and the public perception, if one is a member of the public and has a particular complaint against a doctor, reads Good Medical Practice, it may be that you can identify the paragraph and

say, "Right, the doctor did not do that, so the GMC will act", but, in fact, that is not the position, is it? Because it may be if it is so serious a breach the GMC will act but there will be many failures to comply with Good Medical Practice that would not amount to serious professional misconduct.
A. I think if a complaint was made using that, and there are, then the GMC should take it seriously and look at it. It is the level it reaches and is it recurring

occurrence; is it a very severe breach of Good Medical Practice; which is where there is mixture of judgment and criteria comes in. So I think it is quite legitimate for the public to say, "That is the standard that the GMC is aiming at and they do not seem to have reached it on this particular case of mine. It should be taken seriously." What the outcome of that is will depend on those other factors.

Q. But it may be difficult for a complainant to understand, if it seems in black and white, as though the doctor has not complied with the practice and they are told that this is the document which underpins the GMC's procedures, then to accept that the GMC may decline to act on that. Do you understand the point I am making?

A. I do but then you are driven back to having this list of published criteria, "If this happens we will

take action against the doctor's registration", when actually the GMC -- and it hasn't been the first time I've had the opportunity to mention this morning -- is in my mind the things it has done really well is about raising the overall standard of practice and of the education of doctors for the future.

Where it has I think been overwhelmed by the rise in the numbers of complaints we have said and its fitness to practise procedures were not fit for purpose, and which it has recognised and is now doing something about, arguably should have done sooner. That gets the public attention because it

is in the newspapers when actually and I have visited -- as you will have seen from my CV -- other countries with other systems and I have to say that to have a negative list of criteria done by without involving the judgment and without looking to raise the overall standards I think that we would lose a lot in this country and that is said not as a particular NHS expert, it is someone who actually looks at the overall raising of the quality of standard of health care in the country compared with another countries.
So standards, education, extremely important, therefore, Good Medical Practice should be positive, should

lift the overall. For judging fitness to practise we need to be more transparent about our decisions -- Madam Chairman, your point -- and it would be helpful, and I believe will be absolutely essential going forward, that case examiners have sets of criteria, guidance I would perhaps prefer to use, and if that is not being followed in the judgment then the challenge is showing why so that someone can monitor what is going on.
Q. Just on a slightly different point, one of the matters that Professor Allen was concerned about in relation to the deliberations of both committees which she observed, if we go to _HP0206627^, was the extent to which the Committee considered whether the case would run at the PCC and she says in that first paragraph that we can see that:
"

16 The question of whether a case would run at the PCC was
17 never far beneath the surface in many of the discussions
18 recorded. Indeed, it was specifically mentioned in 50 per
19 cent of the cases heard before November 1999 and in 59 per
20 cent of the cases heard after that date.
21 Then she says:
22 "The question raised was usually related to the
23 extent and nature of the evidence before the PPC, rather
24 than the question of whether the case raised an issue of
25 serious professional misconduct."

1 normal environment where they are very successful into an
2 environment where they are being asked to make decisions of
3 a different kind, then they may import approaches which are
4 not wholly appropriate. So I think it is an amalgam of
5 explanations, partly about a failure by the GMC, as distinct
6 from the individuals, to set out clearly enough approaches
7 to decision-making which would help to ensure consistency.
8 It too often has been assumed that if you take intelligent,
9 well-educated, responsible, well-motivated people and ask
10 them to make a decision you will necessarily get good
11 decision-making. I do not think that is a valid
12 proposition.
13 Q. One of the ingredients which Professor Allen
14 has insisted throughout her reports is the foundation for
15 consistent decision-making is the formulation of agreed
16 standards, criteria, thresholds relating under the current
17 system to what it is that will amount to serious
18 professional misconduct and some sort of hierarchy of
19 seriousness, both to promote consistency between individuals
20 doing the same task (such as the screeners or members of the

Committees) and as between the screeners and each of the relevant Committees so that across the board insofar as one can, human nature being what it is, the same thresholds and standards are being applied.

It does not seem that any real steps have been

made in that direction and I may be mistaken, but in asking various witnesses about this, one detects a certain reluctance to really grapple with this idea. Is that something which you have detected, a reluctance to deal with it, and, if not, why do we not have seven years on from the first report these types of standards and thresholds?

A. I think, uncharacteristically, I would probably start by being more optimistic than perhaps the question as framed would appear. I think that if we take the categories which have been very clearly defined as could not amount to serious professional misconduct, I think they in themselves are a contribution. One might discuss the merits of those categories, but nevertheless they were created and have made a significant contribution to decision-making, including consistency around what could not amount to serious professional misconduct. Similarl, y, and despite the chequered history we have discussed in relation to the interim period as I will label it, there has actually been agreement around issues that should always be regarded as potentially serious professional misconduct such as they should go to the Preliminary Proceedings Committee.

So I think in two important respects we have indeed made progress. I think that leaves, as is always the

24 case, the really difficult area. It is more often than not
25 is connected with allegation of substandard treatment. I am

1 not a doctor, but I detect two things. One is it is
2 genuinely difficult to express some concepts in operational
3 terms. If I may give you an example, my recollection is
4 that the Royal College of General Practitioners' quite
5 splendid piece of work on Good Medical Practice for GPs
6 includes an irrefutable statement which is that being a good
7 general practitioner, an excellent general practitioner,
8 means having excellent record-keeping. I mean, one could
9 hardly argue with that, but to translate that into an
10 operational standard that could be used by decision makers,
11 that is rather a different challenge. So I think there are
12 genuine technical challenges about expressing some of these
13 in concrete terms.
14 But I think sitting beside that there has been
15 a complementary phenomenon which mainly works in the rest of
16 us as patients but goes back to what I was saying a moment
17 ago, may be inappropriate if imported into a different
18 context. I am not a doctor but it seems to me from working
19 with doctors and, indeed, being treated by doctors that when
20 they apply their skills and their knowledge they do so in
21 what decision makers might call a fuzzy sense. They do not
22 follow rigid decision trees; they do not always approach
23 problems by the book. They carry into a consultation
24 a range of experience and skills and specialist knowledge
25 and that soft, fuzzy approach to decision-making, generally

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1 speaking, can work for us as patients.
2 A very good example, if I may just deviate for a
3 moment, if you look in and it certainly used to be the case
4 the AA handbook, it says: if your car does not start, this
5 is what you should do: you should open the bonnet and there
6 are 25 things that you should go through. If I call out the
7 breakdown wagon and say, "My car will not start" he does not
8 do those 25 things. He says, "Oh, it's probably the
9 something or other". He gets to it using what in the trade
10 could be called expert knowledge based on his experience.
11 The point I am rather labouring, and I apologise,
12 is I think that approach is entirely appropriate in some
13 contexts but inappropriate in others. I think into decision
14 making within the GMC has been imported a decision-making
15 model that actually is not appropriate and I think we are
16 discussing one such area.
17 Q. It may be that we return to that tomorrow,
18 particularly in connection with the test.
19 A. I realise I failed in the sense to finish off
20 my conclusion. It is entirely my fault. I think I was
21 wandering somewhere.
22 When we look for consistency and ask why it is
23 screeners or indeed any other group have not bent their
24 backs to devising lists or decision trees and clear criteria
25 I think it is because they genuinely and in a principled way

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1 to hear that you agree that one can logically draw
2 a distinction between conduct and performance procedures.

A. And, indeed, next year there will be no such distinction. It will be part of fitness to practise so I think the distinction that currently exists will become at least in that sense blurred. I have not thought sufficiently clearly through the health implications to get a clear answer on that, which is why I am demurring --
DAME JANET: There are difficulties because it is only pure health that can take place in complete private; is that right?
A. That is right. The example I gave, perhaps badly, is the depressive illness or something of that sort.
MISS SWIFT: There is just one other matter I would like to ask you about and we have touched on it already today and that is the issue of standards, threshold and criteria.
At the moment, a member of the public might read the publication "Good Medical Practice" and be fairly encouraged that if the doctor has breached one of the requirements of that publication, then inevitably disciplining must follow and, of course, we know that that is not the case and for good reason.
The member of the public can gain no explanation of what does constitute serious professional misconduct or

in the future might affect fitness to practise and, equally, neither can a doctor see how far he or she has to go in order to step over the boundary which might result in disciplinary proceedings.
It is some while since Professor Allen drew

attention to this lacuna in the Council's procedures. What has been done about it and what is to be done?
A. It is the codification, as we discussed earlier, about what actually happens at the adjudication panel level, how do people know the remit and it is back to do we require some modifications of the Blue Book. I make the point in any kind of organisation where you are dealing with a large number of people who are motivated, working well and whose support you absolutely require, to indicate the lower levels of acceptable behaviour is a risky thing to do because the vast majority of the medical profession the horizon is way, way beyond anything we are going to pick up at fitness to practise.
So if you indicate only the deficiencies, then I think you actually run the risk of disaffecting large numbers of the profession and that is true at undergraduate level when you are setting exams. The vast majority of students should soar beyond minimum acceptable standard. Having said that, it is clearly important that we do define much more clearly which is unacceptable and

I think we do that not in a hidden way because we need to do this transparently but we do it with a view to helping the adjudication panels rather than in an attempt to help the rest of the medical profession because I do not think it will have that effect at all. I do not believe that people look how far, how low they can reach and get away with when they are planning their careers and so on. So my view is reach the horizons, go to the stars, but actually let us

have a look in much more practical detail getting a manual that is based on something like the Blue Book that indicates much more clearly and effectively to panel members, associates and, of course, the profession and the public because it would have to be made available on the website or whatever, that which has constituted practice that is unacceptable.

DAME JANET: I am sure you are right that doctors do not think about how low they can fall any more than ordinary citizens by and large think how low they can fall in respect of breaches of the criminal law, but just as one has to have clear standards of conduct for ordinary life and we have a criminal law, you must have some ideas and you must surely make them plain so that people do understand what is not acceptable?

A. I think it is inevitable. I am sure that will happen. It will make unedifying reading to indicate that

you should not sexually assault a patient while true -- does not make happy reading. Nevertheless I very much accept that we will need to make these things much more explicitly clear than perhaps we have done.

DAME JANET: I must confess it has disappointed me that when the opportunity came for the reestablishing of a test under the new procedures that the test is somewhat circular, that you will be brought before the panel if your conduct or -- I cannot remember the very wording, but I am sure that you have it your fingertips --

A. If your fitness to practise is impaired to

such an intent that there should be restrictions placed on your licence to practice.

DAME JANET: Do you see what I mean?

A. I do. I think there are several aspects to that statement. One is that on its own it is I suspect entirely meaningless. You need to be part of the tribe before you can actually understand what it meant. So I think any help that you could provide would be gratefully accepted.

DAME JANET: I was interested -- today I read a response to our latest consultation paper, or perhaps it was last night, it came from an eminent psychiatrist who said that the test was absolutely fine because it was quite clear and I have no doubt that it is to him but I have

little doubt also that it is not clear to very many other people and I suspect most members of the public.

A. It may be, Madam Chairman, that the test is inappropriate, or it may be that the test is appropriate but the explanation is obtuse, not clear.

DAME JANET: The test may have to stand but it must surely be explained as a body as part of the test.

A. I very much agree with that. Somehow or other we need to -- we, the GMC, perhaps with your help -- need to put that in context so that people can understand what it actually means.

MISS SWIFT: One of the matters that was exposed in Professor Allen's second report when she carried out the comparison of screener decision forms and observed the PPC

was the practical effect of not having agreed standards and criteria. She did not carry that through to the whole process through to the PCC, but there appears little reason why there should not be the same sort of confusion there. Why has there been a reluctance to embrace this and to realise that the only prospect of getting consistency within the organisation is to have some sort of standards, criteria, thresholds, at least for the use of personnel within the Council?
A. I think if we agree that sanctions guidance, there needs to be clear and more generally available as

clearly essential, then I think that is one way forward. Why has it taken so long? I think perhaps because the perception that consistency and lack of guidance was a problem is a relatively recent phenomenon. It has only been within the last few years that there have been so many different panels and groups and people looking at the fitness to practise arrangements before that as we indicated before, for better or for worse, it was relatively tightly controlled by a very small number of individuals.
DAME JANET: When did this proliferation take place, because I had the impression that it was rather later than Isobel Allen's first report in which she did make this recommendation?
A. The big increase in numbers was in 1995 so that the numbers of complaints coming to the GMC trebled between 1995 and 2,000 from 1,500 to 4,500 but there have been a ramp up in the years before 1995. So I think

18 although Isobel Allen identified it at an early stage,
19 I think awareness of what she was describing was slow to be
20 understood in a big Council of 105. I am speculating. I do
21 not know the specific answer.
22 I think it is not ill-will; it was a slowness to
23 proceed.
24 MISS SWIFT: I would not suggest from time to time
25 it was ill-will. Was it perhaps because it was anticipated

15:25:12 1 nothing in it would prevent the patient protection down
15:25:16 2 whichever route when the case is heard for the doctor to be
15:25:20 3 suspended or to be subjected to conditions.
15:25:24 4 MISS SWIFT: What I was really seeking to ask you
15:25:30 5 about, Dr Korlipara, was not the cases of such seriousness
15:25:35 6 that immediate action is required, but was whether there was
15:25:41 7 a difficulty which you face as a screener in looking at
15:25:47 8 a complaint and deciding -- a complaint of substandard
15:25:52 9 treatment and deciding whether or not it could amount to
15:25:58 10 serious professional misconduct?
15:26:00 11 A. As I acknowledged, madam, there are occasions
15:26:05 12 when I do have to close the book and go for a walk and
15:26:09 13 reflect which route it is best proceeded, but if it is quite
15:26:17 14 clearly one of substandard treatment and no patient has come
15:26:21 15 to harm, I have to admit I allow my mind to think loudly,
15:26:29 16 just as I do that if the substandard treatment, patients are
15:26:35 17 better helped if there is any chance that the doctor could
15:26:38 18 be usefully rehabilitated, even though it may mean an
15:26:43 19 interregnum during which conditions are applied under
15:26:47 20 suspensions.
15:26:48 21 In a roundabout way I am accepting
15:26:51 22 there are difficulties, but I am also saying we are

15:26:54 23 not at any time compromising the patient safety and
15:26:58 24 we are taking the overall picture of one alternative
15:27:01 25 against another, the usefulness of the doctor by

1 being rerouted against the possibility down the
2 conduct route where such procedures are not open to
3 Conduct Committees.
4 Q. Can I just ask you a slightly different point,
5 although part of the same issue. Are there difficulties in
6 the GMC, and you as a screener on behalf of the GMC, in
7 satisfying public expectations in relation to treatment
15:27:39 8 which may fall below acceptable standards but which, in your
15:27:45 9 view, could not amount to serious professional misconduct?
15:27:49 10 A. The direct answer, madam, is that there are
15:27:53 11 difficulties. The difficulties are those of communicating
15:27:57 12 effectively as to the basis upon which reasonable decisions
15:28:03 13 have been made. It is not the decision itself, it is the
15:28:08 14 ability to share with the public the basis on which the
15:28:13 15 decisions are made, the reasonableness and how best both the
15:28:18 16 public are protected and the doctor rehabilitated.
15:28:21 17 Q. So you feel that it is very important to
15:28:29 18 communicate the reasons for the decision to the public in
15:28:34 19 a case where the complainant might be disappointed that the
15:28:38 20 case cannot go further? Is that what you are saying?
15:28:43 21 A. Absolutely right, madam. I believe as
15:28:46 22 a matter of principle that in all our dealings, especially
15:28:50 23 in the doctors and the GMC, both in their individual roles
15:28:54 24 as well as in the corporate governance, it is extremely
15:28:57 25 important not only to be doing right but to be communicating

15:29:01 1 to our audience that what we are doing is, in fact,
15:29:06 2 reasonable and right.
15:29:06 3 Q. Do you think that the public does properly
15:29:14 4 understand and, indeed, accept the sort of threshold that
15:29:21 5 the GMC sets for what constitutes serious professional
15:29:26 6 misconduct?
15:29:29 7 A. I put my hands up in the air again to say that
15:29:34 8 as GMC, we could do better by explaining more rather than
15:29:40 9 use more or less the same language adapted to every
15:29:48 10 complaint.
15:29:51 11 Q. One issue for the future and one issue that
15:29:54 12 you -- I appreciate you are not going to go forward as
15:29:59 13 a screener -- would face if you were a case examiner, for
15:30:05 14 example, and the case examiners will face, one important
15:30:08 15 issue is going to be the new definition because, as we
15:30:14 16 understand it, serious professional misconduct is to go,
15:30:19 17 seriously deficient performance is to go and instead the
15:30:26 18 question that the case examiner will be asking him or
15:30:29 19 herself is, "Is there a realistic prospect of establishing
15:30:34 20 that a doctor's fitness to practise is impaired to a degree
15:30:39 21 justifying action on his or her registration?"
15:30:42 22 Have I understand the position correctly, first of
15:30:47 23 all, Dr Korlipara?
15:30:48 24 A. I think if I understand correctly you are
15:30:51 25 asking will the case examiners be happy they work with this

15:30:55 1 new --
15:30:55 2 Q. First of all, I am establishing that I have
15:30:58 3 understood the position correctly and that is the definition
15:31:01 4 they will be working within?
15:31:02 5 A. I think that is correct.
15:31:04 6 Q. Putting yourself with your experience in their
15:31:08 7 case, how easy or difficult would you think it is going to
15:31:14 8 be, first of all, to work out exactly what that means and
15:31:21 9 how to apply it?
15:31:22 10 A. If I was a case examiner with absolutely no
15:31:26 11 training, I would find that more cumbersome to understand
15:31:31 12 than SPM/SDP but I am being extremely harsh on the case
15:31:40 13 examiners who I am not crediting with having had proper
15:31:43 14 training. They will be given proper training and there will
15:31:50 15 be some dummy experiences with them, rehearsals, so that
15:31:54 16 they will be comfortable before they actually come to do
15:31:58 17 their job.
15:32:00 18 Q. Somebody is going to have to determine the
15:32:05 19 threshold of the degree of impairment which justifies or may
15:32:11 20 justify action on registration. That is right, is it not?
15:32:16 21 A. That's right.
15:32:17 22 Q. Somebody is going to have to set that
15:32:20 23 threshold.
15:32:20 24 A. Yes.
15:32:21 25 Q. How do you envisage that being done?

15:32:23 1 A. It is early days yet but I will speculate,
15:32:29 2 madam. They will be given the training to err on the side

15:32:33 3 of caution and to refer to the Investigations Committee if
15:32:38 4 they are not sure. I hope the Investigations Committee
15:32:43 5 which will have the majority of decision-making as to
15:32:49 6 whether the case should be closed or the case should proceed
15:32:54 7 down one of the routes will see a much greater proportion of
15:32:59 8 all cases screened by the case examiners, at least until
15:33:04 9 they are satisfied that the case examiners are making
15:33:10 10 appropriate decisions, even if it means there is a greater
15:33:14 11 workload in the initial months.
15:33:15 12 Q. How is the public going to understand what
15:33:20 13 that definition means?
15:33:21 14 A. The fitness to practise I think is both
15:33:28 15 a mouthful as well as sounds somewhat remote for the average
15:33:33 16 Joe Public, but it is not going to replace it. The conduct
15:33:39 17 or the performance, et cetera, it is the term used by the
15:33:46 18 case examiners who only use it as a language for them to
15:33:58 19 refer the patients who will still be judged ultimately on
15:34:04 20 whether or not their conduct or the performance are
15:34:09 21 impaired, either through irresponsible actions or by reason
15:34:15 22 of impairment.
15:34:16 23 I think the public will need to be --
15:34:19 24 we need to communicate to the public better that the
15:34:21 25 system that is going to be introduced, in fact, will

15:34:25 1 be an improved version of the current unsatisfactory
15:34:29 2 system where investigations can be undertaken much
15:34:33 3 nearer the starting point and, therefore, the
15:34:38 4 decisions will be much more rationalised and also
15:34:42 5 there is going to be a greater flexibility rather

15:34:44 6 than cases being put into the pigeon hole of one or
15:34:49 7 the other.
15:34:51 8 Q. If a member of the public has before him or
15:34:55 9 her a copy of Good Medical Practice which we understand
15:35:02 10 underpins the GMC's procedures and, in particular, the
15:35:07 11 fitness to practise procedures and this definition of when
15:35:13 12 the GMC will act, how are they to marry up the two? How are
15:35:26 13 they to know from those two documents what is going to
15:35:32 14 effect fitness to practise and what is not?
15:35:34 15 A. I think it requires a little bit of the word
15:35:40 16 I used before "communication", communication to the public
15:35:45 17 in plain English that conduct which is unbecoming of
15:35:52 18 a doctor or performance below that which is acceptable to
15:35:57 19 a reasonable doctor should be the subject of complaint and
15:36:05 20 there should be an explanation of how the GMC takes this
15:36:08 21 forward and if the GMC communicates, at the risk of
15:36:16 22 repeating myself, effectively in plain English, how it is
15:36:19 23 going to take this forward, then it will be a simple
15:36:22 24 process, more effective, I think publ, ic will have confidence
15:36:26 25 in a system which they understand.

15:36:27 1 Q. Is one of the problems the fact that whether
15:36:34 2 you use the present definitions or the new definitions,
15:36:45 3 individuals -- be they individual members of the GMC or
15:36:49 4 individual members of the medical profession or individual
15:36:51 5 members of the public -- will have different thresholds for
15:37:00 6 where they believe action should take place?
15:37:03 7 A. Yes, I understand that, madam. I had hoped
15:37:09 8 but obviously I have not put it well that these different

15:37:15 9 thresholds the GMC will neatly explain to the public after
15:37:20 10 making sure that proper elements have been met that the
15:37:25 11 decision ultimately does not rest with the case examiners,
15:37:29 12 it rests with the Investigations Committee which consists of
15:37:34 13 a number of medical members and the lay members, so that
15:37:38 14 there is public/professional partnership and decisions are
15:37:43 15 not left to the lottery of one case examiner arriving at
15:37:49 16 a queer decision and, therefore, the decisions will be much
15:37:56 17 more considered and will be speedier than that we have seen
15:38:02 18 today.
15:38:03 19 DAME JANET: But, of course, the decisions of the
15:38:06 20 Investigation Committee will not be made in public and they
15:38:09 21 will not be published, will they?
15:38:12 22 A. That is true, Madam Chairman. That is one of
15:38:14 23 the problems.
15:38:15 24 DAME JANET: So what you have in mind is that the
15:38:18 25 system should be explained to the public in plain English as

1 DR LEWIS: I think I would. Falsifying notes
2 would be a matter for the GMC to consider. It certainly
3 would not be closed at screening, in my experience.
4 MISS SWIFT: But, of course, we do know that the
5 XXX case was closed at screening and there was no mention
6 that -- it may be that it was not appreciated that an
7 inevitable inference of the Medical Services Committee
8 finding was that those notes must have been falsified
9 because they said, "No change in condition." That is just
10 an example of something that the GMC could put beyond doubt
11 in criteria. Would you agree with that?

DR LEWIS: Yes, it could.
MISS SWIFT: I appreciate that that is perhaps more black and white than some areas.
Sir Donald, you are I think nodding. Do you have anything to add on this?
SIR DONALD: I think this goes to the nub of the whole question because if there is not clarity about what good practice is, what the serious departures are and what the possible sanctions will be, all the system underneath it will find it very difficult to operate. The GMC is responsible for this, because it keeps the Register and the requirements to get on and stay on the Register.
As you know, I have regarded the statement of the principles of good practice, Good Medical Practice, as the

starting point but in my evidence before Christmas, I went on to say that the next major piece of work had to be the fleshing out by the Council of what it meant by unacceptable behaviour which would address the whole questions of what is unacceptable behaviour in different categories, as the Chairman is referring to, but also would deal with threshold.
There are a whole range of ways and it would require several ways to address this. The Council I think will have to do this because the committees, the new committees particularly disconnected from the Council, as they are at arm's length, will really find it difficult themselves to know, to make up their minds.
DAME JANET: You mean the hearing panels?

SIR DONALD: Absolutely. So I could see all sorts of inconsistencies arising if this work is not done. I just wanted to say the moment is approaching also when a problem that several of us have been talking about for several years -- it has been in the background but coming steadily to the fore -- has to be addressed and that is the gap which patients notice between the statements in Good Medical Practice and what actually happens, not just the threshold, but the sanction that is imposed when there is a serious breach. It has been my contention that eventually the Council would have to reduce the gap so that the thing was

credible.
There are a number of ways in which this could be done. If one takes the example you have raised about dishonesty, I think -- was that right?
MISS SWIFT: Falsification of notes.
SIR DONALD: I mean, there are categories of offence like that -- research misconduct is another -- where the Council could state quite categorically, "If this is what happens, you can certainly expect it is certainly Serious Professional Misconduct and this is the kind of sanction you can expect, unless there are mitigating circumstances. For falsification and lying, you would expect to be removed from the Register unless you could show very, very good reasons why not" and so on.
So building up a pattern of category would be important. I think it cannot be limited to the kind of cases which come eventually to the Council because I am sure

18 the discussion will take us in a minute into the lesser
19 cases which are not SPM but which are not good practice and
20 are nevertheless a concern of the Council because the
21 Council is concerned about everybody sustaining a good
22 standard of practice. So all the grey area things which you
23 were referring to earlier on, it has to be able to help
24 people navigate their way through that boundary. So there
25 is quite a complicated mapping exercise but I do not think

1 that it will be all that difficult given now the acceptance
2 that there is within the profession and broadly speaking
3 with the public about the main headings which are in Good
4 Medical Practice.
5 This last point I was thinking while Malcolm Lewis
6 was talking in terms of records. If you look at Good
7 Medical Practice and I just opened it in my book pinched
8 from the GMC, on page 3 it says -- it is very explicit and
9 I will just read it for you:
10 "Keep clear, accurate, legible and contemporaneous
11 patient records which report the relevant clinical findings,
12 the decisions made, the information given to patients and
13 any drugs or other treatment prescribed."
14 It is a pretty explicit, testable standard to
15 which you can adduce quite objective evidence to come to
16 a conclusion. I am reminded that the Joint Committee on
17 Postgraduate Training for general practice years ago made
18 that kind of explicit requirement, a requirement for
19 training practices. It set out a set of quite explicit
20 standards. The records will be in date order, filleted,

clear, you know, these sorts of principles and then started to apply that quite rigorously, the ultimate sanction of which was, of course, if you did not do that, you lost your teaching status or if you were a new applicant, you did not get it in the first place.

behaviour. If you do that, you are not going to get any support from me. That is not an appropriate way to conduct yourself."

I think it is that kind of strength that will have to be developed and that will mean a very systematic piece of work, but it starts with the Council itself, with the Colleges building on the work that they are doing but defining these exceptions and the penalties that the breach should attract.

DAME JANET: And, indeed, the threshold of when a matter becomes serious enough to go to the GMC as opposed to when it stays at a local level. It does seem to me that that is important because it just is not satisfactory for the GMC to be overloaded.

SIR DONALD: I think in terms also, if one leaves conduct to one side for a minute and thinks about performance, to see these developments in the context of the new technologies which are going to quite revolutionalise how doctors learn and the building-in of continuous assessment in one form or another to that learning so that the demonstration of knowledge and clinical skill and other relevant skills becomes a normal way of practice.

As recently as 1995, when we produced Good Medical Practice, those technologies were but a gleam in the eye.

But we heard last week, particularly from

Professor Southgate, how quickly the world has moved on. I think it is going to be immensely helpful in making decisions about what is poor performance, for example, seriously deficient performance, if one is clear in a general practitioner, well what knowledge is it that we are talking about? What is it that you are supposed to be up-to-date in? What skills should be thoroughly proficient in? How will that have been tested? How will that have been evaluated? And so on and so forth. I hope that we will be forward-looking in this and positive in anticipating that this is the way that medicine is going, that these will become the normal ways of doing things and construct the system round that. I think it will be enormously helpful.

DR LEWIS: I was just thinking of the new definition or standard, if you like, that will be applied at the Adjudication Committee and that is that the doctor's fitness to practise will be impaired to a degree that should justify action on his or her registration and this will replace the Serious Professional Misconduct and seriously deficient performance judgments that are made at that stage. Yet this discussion has already fallen into two quite distinct categories: those of conduct and performance. We have heard about NICE guidelines and performance issues which are very different from I think where we started this discussion what was around conduct matters and defining

codes of conduct, I believe, in terms of how doctors might identify where they would fall away from the expected standard of conduct and what would constitute by definition a list of categories or items of conduct that would amount to at the moment Serious Professional Misconduct and what sanctions might be applied if those allegations were proved against the doctor.

So I think it is terribly difficult to kind of amalgamate the two when we are looking at codes. I think it would be very difficult to have a rolling list of NICE guidelines or other guidelines in the professional performance context that we could keep updating because, as we have heard, it changes all the time and also some guidelines that are produced in individual clinical categories perhaps some from aspects in one clinical area, for example, like diabetes or hypertension with diabetes, yet patients that are seen in the context of general practice are very idiosyncratic and they bring with them far more than one disease -- they often bring three or four -- and they also bring many other social and psychological factors that influence the implementation of those guidelines. So there are very complex issues to consider when you are looking at individuals when they are moving away from delivery of guidelines.

DAME JANET: Are you saying you do not think

guidelines are of very much practical use or are you saying that you do not really think that criteria are feasible?

DR LEWIS: I think that criteria are feasible.

I think that guidelines are useful in practice but they are not always implementable to the word of the guideline -- departures.

DAME JANET: I think both Professor Baker and I made that point, that you cannot just, apply them as a hard and fast rule. There has to be clinical judgment involved, but that does not mean to say they are not a good idea to have.

DR LEWIS: No, I agree with you entirely. I think they are a very good idea and very useful.

Coming back to the conduct issue and the definitive list of offences, it is not in my nature to avoid doing something because it seems impossible from the outset but I note that this has not been done elsewhere in the world and that the Judicial Committee of the Privy Council have recognised that such an enterprise would not be practicable because of changes in practice and so on. However, I am not sure that these changes apply largely to conduct matters. If you are a thief today you are a thief in ten years' time, and so on. So I think that we could do a little bit more work on the conduct side.

DAME JANET: You know, with enormous respect to

of it?

MR FORREST: Yes, exactly.

MISS SWIFT: So is the position that what criteria the GMC or any other regulator has as to what constitutes serious impairment in a fitness to practise in the GMC's case is not a matter with the CHRP; it is only an issue of what happens to a doctor who is convicted, as it were?

MR FORREST: That is correct on the face of

things, although it is something that we are interested in. The point is that the internal consistency of the GMC is less important to us than how that translates into the protection of the public. For example, if they were to have a set of guidelines which consistently came up with the same outcome but that we felt that that outcome was not adequately protecting the public, then we have a mechanism for perhaps trying to have that reviewed.

DAME JANET: So that if they did develop some guidelines, some criteria rather, as to the threshold at which they were interested in accepting a case, that would surely be a matter of interest to your body because if they were setting it too high, it might not be protecting the public.

MR FORREST: Absolutely. In fact, it is one of our four statutory functions, to try and stimulate good practice and share it between regulators.

DAME JANET: Good practice in all possible respects?

MR FORREST: Exactly. That is in section 26 (2) of the Act that governs our work.

DAME JANET: Has the CRHP yet applied its mind to the question of standards and criteria for disciplinary action or action against professionals by a professional body? Have you reached that stage yet or not?

MR FORREST: No, we are at the stage in our own organisation of looking at the criteria that we would use to make our tests. We had a consultation exercise on this

12 legislation and one of the public concerns transmitted back
13 to us was overdelegation to my function, was I being left
14 with a kind of unguided right to make decisions as to who
15 should be referred to the High Court and who should not?
16 What the Council is working on -- and we go to our
17 Council meeting in February -- is developing a structure
18 that would provide the tramlines within which my delegation
19 works, my right to make a decision should be guided by the
20 Council as a whole in their perception of what is acceptable
21 and unacceptable.
22 DAME JANET: So it would be another stage down the
23 line before you began to look at the criteria of the nine
24 bodies.
25 MR FORREST: We have engaged external researchers

1 to do a scoping study on how each of the nine regulators in
2 the UK does its business and this is the starting point for
3 us looking for how we could look at good practice and its
4 transmission between the nine regulators.
5 MISS SWIFT: Is it intended in that research to
6 look at specific decisions, individual decisions, reached by
7 the regulators to test whether they are applying any
8 criteria and if so, they are applying them correctly?
9 MR FORREST: Not in that study but another
10 document that is going to the February Council is an
11 accountability structure for how the CRHP does its business,
12 which would see a subcommittee of our Council. The Council
13 as you know is composed of the nine Presidents of the
14 regulatory bodies and ten members of the public, and we are

15 hoping to devise a subcommittee of that that will come in
16 and look at the decision-making process internally within
17 our office. For example, of the 150-odd cases that we have
18 reviewed, which is every finding of Serious Professional
19 Misconduct or its equivalent across the nine regulators
20 since we were established in April, only two cases have
21 ended up in the High Court and only about 15 or 16 have
22 ended up in a panel, as you would say, a subcommittee,
23 looking at whether they should go to court or not. Clearly
24 our concern is to develop defensible criteria that reviews
25 how the ones just, as Dr Lewis was saying, the decision of

1 what is screened and is that appropriate. So I think we are
2 still internally developing our view on standards.
3 DAME JANET: Do you only consider cases where
4 there has been a positive finding?
5 MR FORREST: No. We have considered in one of the
6 cases at court just now where there has been an absence of
7 finding.
8 DAME JANET: But you do not look at cases that are
9 screened-out before the final hearing stage and you have
10 no -- do you have jurisdiction?
11 MR FORREST: No.
12 DAME JANET: You do not have jurisdiction to do
13 that.
14 MR FORREST: We do not have jurisdiction in either
15 the Preliminary Proceedings Committees, the Health
16 Committees or the Interim Orders Committees or the
17 Registration Committees of the GMC.

DAME JANET: Under their new system you, I take it, will not have jurisdiction to look at the decisions of the Investigation Committee or decisions taken under their umbrella?
MR FORREST: That would be correct.
DAME JANET: Pity.
MISS SWIFT: Do you anticipate that you will ever be able to look at the over 90 per cent of cases that do not

get to the final Committee because arguably it may be in those cases where certainly the greatest concern lies?
MR FORREST: One of our statutory functions is to indulge in performance review with each of the regulators and the first round of that for the current financial year will be completed by the end of March which will initially involve us discussing with them performance around about how they do their functions. I think perhaps in the future that may develop into this balance between that which ends up at one Committee and that which does not.
DAME JANET: Does a performance review allow you to do a random sample of what has actually happened in practice, do you know?
MR FORREST: At the early stage for the current year it would involve us reviewing statistical inconsistencies amongst the data that is collected for statutory purposes. So it is a developing area. The first one is going to be about reviewing what they currently collect and what they currently do with that information.
SIR DONALD: I just wanted to go back to this

question of evidence and criteria. Specifically in relation to general practice, just to remind ourselves that general practice is the only discipline in medicine where there has been open-ended entry until 1998. So you have a spectrum, a range of competence and performance far wider than in the

hospital specialties and in public health medicine.
That plays itself out at the ultimate point in my experience actually in the privacy of the Fitness to Practise Committees when they go into camera to decide what to do with the facts and particularly about disposal. It is at that level that the absence of criteria around the clinical areas to which you were referring, Miss Swift, becomes so crucially important because what actually happens is that it emerges as a kind of conversation in which people simply share their opinions about what good general practice is or is not and at that point things have departed from what the Royal College standard is or even what the GMC's own standards are. It is amazing how many times Chairmen just have to remind themselves or be brought back just to remind what the Good Medical Practice basic standards actually are.
It seems to me that until that piece is tackled, it is quite difficult because people who have come into a specialty, into general practice, believing that, "I have arrived and I have got through the system", and yet actually may themselves be deficient. There are some people I have seen adjudicating who ought not be practising there are bits of the records and then there are not ... it is just a fact

that there is a problem and the Council has to resolve that problem first.

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When it can do that, it can begin to start to talk to the PCTs, to patients, to other people and it will begin to get some consistency in what actually happens, what decisions are made and start to resolve the awkward gap that too often occurs when a PCT refers a case on and then, apparently for bizarre reasons, nothing that you would expect to happen actually does happen.

DAME JANET: This is to some extent a reflection of what Dame Lesley was talking about early last week, I think, when she said that an assessment report based on the GMC assessment might be pulled apart a little bit by the lawyers in a hearing and then the finding is that the doctor is fit to continue in practice where in fact the GMC's own assessment process has thrown up some very serious concerns about him.

SIR DONALD: I thought she explained it very well --

DAME JANET: I did.

SIR DONALD: -- like a Matisse picture. I know that method gave concerns to the lawyers originally because it was not about specific pieces of evidence that could be tested, it was a picture but nevertheless I think we are past the stage now where the validity of that is in question. It has with stood the legal testing. But you are absolutely right, and she is absolutely right and I have

a background of working within the Health Service. So there are three who I think have no background at all of working in health. So in this context I think they could be seen as "lay lay" as opposed to pseudo lay, if that is a phrase that I can use.

The issue about appeals is I think there has to be some kind of threshold for people to reach in being allowed an appeal and that is certainly the case in law for any appeals and whether that threshold is to do with failure to follow procedures and rules or whether it is to do with what might seem to be an irrational decision rather than a decision with which the complainant is not happy and would, therefore, seek a second opinion --

DAME JANET: Those are the criteria for Judicial Review that you have just set out and the view that has been expressed up to now is that that is too narrow a basis for the kind of appeal or review that people seek.

DR LEWIS: I think that there are other strands of discussions that we have had in these seminars that feed into this process. The first is to do with the input -- that is the nature of the complaints that come to the GMC -- and the information that perhaps is not adequately in the public domain about what should come to the GMC and what should be dealt with elsewhere since the cases do not have to be referred back into other systems in the way that

that come through and therefore the 90 per cent that are currently closed at a very early stage.
The other aspect is the explanation for closure which again we have touched on. Although we are working on this and it is better than it was, the fact that the decision protocol format would be used by the Case Examiners, as you referred to Madam Chairman, will I think enhance the quality of explanations given to complainants. We will categorise the aspects of the complaint and will in each category allow the Case Examiner to give reasons as to why it has been closed or, indeed, progressing. So the actual template for arriving at a decision will be far more clear and transparent and, again, in the public domain.
DAME JANET: Is it intended that exactly the same material will go to the doctor as goes to the complainant; do you know?
DR LEWIS: I do not know the answer to that. At the moment, the letters to doctors tend to be less descriptive than those that go to patients, particularly in terms of closure obviously. The difficulty again that you referred to, Madam Chairman, in terms of closure for the doctor is that under the current legislation -- and again I have referred to this in previous discussions at the seminars -- the performance procedures are allowed to review

a case within three years and the conduct procedures within two years. So it is not possible, unfortunately or quite properly in some cases, for there to be absolute closure on any case at that stage.

Coming back to closure and the explanations, one would hope that better explanations and more clarity for complainants whether from public bodies or individual patients, might result in a better acceptance of the result that has come from the GMC where that result is closure. It might reduce the number that would require appeal, but I think there is still a heavy burden to be carried if there is an ability to appeal simply on the basis of being unhappy with the decision that has been reached.

MISS SWIFT: Dr Lewis, can I just try and illustrate the problem by an example. I think it has been the case in the past that cases that are screened out are not seen, are not examined, are not monitored by anybody within the GMC; is that right?

DR LEWIS: There is no formal mechanism of reviewing all of the decisions made at the screening level. There are reviews in terms of, if you like, quantitative aspects --

DAME JANET: Service procedures, your targets and all that.

DR LEWIS: Indeed, absolutely.

case you recognise it when you see it.

DAME JANET: May I ask you: have you ever sat as a Magistrate?

SIR DONALD: No.

DAME JANET: Because I was interested in Mrs Robins' view of the problem where you are pretty sure he has done it, but you really could not hand on heart say that you are sure, and I have presided over jury trials where I have been pretty sure that that has been their state of

mind and I can understand that it would have been mine. Of course it may well be that lawyers apply the rule much more strictly than a group of doctors do sitting on a panel.
SIR DONALD: Yes, although we have been blessed with some very good legal assessors and the in camera comments rather than formal advice have often been extremely helpful in assisting that process. Of course, missing from this discussion so far is the in camera discussion amongst the members of the panel in which the evidence is tested, the arguments are all tested. That is a very, very important part of the process of arriving at precisely, so is it an elephant or is it not? So I agree with you. It is not as difficult as it theoretically appears.
DAME JANET: But your experience from sitting on GMC panels is that when it comes to the findings of fact, you really have not had any difficulty and you have never

had any real discussions about not absolutely sure but I think he did it but we are not going to find it because we are not sure; that sort of discussion has not happened?
SIR DONALD: No. I have seen quite a cogent argument about the quality of evidence, the way in which that evidence has been presented and tested and I have seen some really very, very searching discussions inside those panels where that has been reviewed but with nothing like the heat that I have seen and emotion that can sometimes flow later when you get to the issue of Serious Professional Misconduct and sanction. In my experience, those are the contentious and the difficult pieces of the process as far

as the members are concerned. Relatively speaking, the finding of fact is more straightforward.

DAME JANET: So really you are saying this is something of a non-issue.

SIR DONALD: I have always regarded it as essentially a non-issue. The central issue is what is Serious Professional Misconduct, where is the threshold and what do you do? Those are the bits, of course, that are reflected in the outcome as far as the public is concerned and as far as the profession are concerned.

DAME JANET: Of course, you do not give reasons in the degree of detail that would reveal -- well, not usually. I know that you have done in one or two cases but in

general, the GMC does not give a detailed decision which would break down into findings of facts, conclusions on the issue of Serious Professional Misconduct and then moving on to sanctions.

SIR DONALD: Yes, I think -- I mean, one of the helpful things that Privy Council has done in recent years is to promote the notion of proper explanation. There was a time, of course, as you will remember, when the Privy Council itself did not think any of that was necessary.

DAME JANET: We all know better now.

SIR DONALD: We all know better now. I believe and am firmly committed to the view that proper explanation at each stage of the process is a good discipline just as it is a good discipline in the clinical decision-making process

16 so that people can see. But the decisions, the
17 explanations, really need to be most focused on the issue of
18 was it Serious Professional Misconduct or not and on the
19 reason for the sanction.
20 I think a lot of ordinary people that I have met
21 have been able to accept a determination where the facts
22 were not found proved. Remember, if we bear in mind that
23 these hearings are all in public and lots of people will
24 have all heard the evidence themselves and been able to make
25 up their own minds, the contentious pieces start when you

1 find the facts proved and then you think to yourself how
2 could they possibly conclude from that that it was not
3 Serious Professional Misconduct, or if they did conclude it
4 was --
5 DAME JANET: Why did they not strike him off?
6 SIR DONALD: Why did they not do X, Y or Z and it
7 is the clarity of the explanation of those decisions and the
8 improvement of that part of the process I think which will
9 provide the biggest yield in terms of effectiveness and
10 acceptability as far as the outside world is concerned.
11 DAME JANET: I would just like to ask Dr Grenville
12 what his reaction is to learning that, really, in
13 Sir Donald's quite extensive experience, the issue of
14 standard of proof as to the facts is really never a matter
15 of discussion or contention.
16 Does it surprise you?
17 DR GRENVILLE: No, I do not think it does partly
18 because having been involved in the trial of Shipman and

having been involved in a number of police investigations since, I perhaps have more experience of matters of standard of proof than many of my colleagues and I am aware that it is a difficult area.
DAME JANET: It may be that if the issue of standard of proof is to be focused upon properly and if doctors regard it as important for their protection, that

is all about life and death, or it could be. So I have to have complete trust in the doctor and, therefore, I have to be able to satisfy myself, if I choose to, and using the ways in which I choose to do so, to do that.
So that may be slightly harsh on the profession but then the profession claims a particular position of trust with the community and so they have to take exceptional steps to justify that, in exactly the same way, Miss Swift, if we went back to the dishonesty issue there may be an argument for the profession taking a robuster view about what you do about dishonesty in the context of medical practice which may be more robust than you would take with a citizen, including that doctor, in ordinary life. You could make that case.
That is the kind of situation I think that needs to be explored. It is the kind of debate we have not had.
MISS SWIFT: I would like to come on to another topic, Sir Donald. One of the themes of Professor Allen's work was the lack of agreed and understood standards, criteria and thresholds, in particular as to what constitutes serious professional misconduct. You recall that she was able to show clear evidence of differences of perception, between perceptions of risk and seriousness and

24 outcomes as between screeners and also she observed the
25 difficulties which members of the PPC had in resolving the

1 issue of thresholds and standards.
2 It is perhaps worth mentioning also that
3 Mrs Robinson, to whom we have already referred, also
4 identified this problem back in 1988 if we go to _HD0700017^
5 bottom right hand corner when she talks about the difference
6 between the way in which doctors and lay people are likely
7 to judge apparent lapses in medical care.
8 "If an error has resulted in death or major injury
9 the public naturally will see this as a serious offence and
10 one which should be severely dealt with. However, from the
11 medical point of view, the error made by the doctor may not
12 indicate such a poor standard of practice as one which had
13 a more fortunate outcome."
14 Then she says that:
15 "Lay members become better at understanding the
16 medical arguments but it is also important to try to keep
17 a common sense base of 'does that sound reasonable?' It is
18 easy to see how medical and public concepts of justice may
19 differ. I would like to see more discussion of the ethical
20 and legal problems involved in such cases."
21 Perhaps that is an echo or a precursor of the
22 view you have been expressing:
23 "If the GMC continues its apparent policy of lofty
24 unconcern when values clash, there will be even more
25 criticism."

Then she goes on to say:
"During my time on the Committee I learned much from my fellow members and acquired a great deal of respect for them. It became clear that there could be a number of different medical views as to whether a particular case might or might not be serious professional misconduct. How, I wondered, could one doctor acting as preliminary screener make such a decision alone on the many complaints which were rejected before reaching us? Curiouser and curiouser, most curious of all why was I the only member who wanted to know more about them?"
She is making there she may not have been perhaps the only member who was wanting to know but was expressing her concern about differences in standards and criteria back in 1988.
How do you believe that this problem should be addressed if, indeed, you agree that a problem exists?
A. I think the first point to make is that the attempts at resolution within the fitness to practise machinery it is not necessarily the best place to do it and I have argued elsewhere -- and it is in the book -- that the standards are the place where these matters should be developed and if one looks at the work of the Council, for example, led by Rabbi Julia Noyburger(?) and Sir Cyril Chandler on the development of the GMC's position and

profession's position on consent which goes beyond the law -- it is a good example of an area where one is arguing the profession has to take special responsibilities -- that is to my mind a case study of how this sort of thing might be taken forward.
That booklet -- the advice in that booklet is used internationally now as a model of a reasoned position and, of course, it has come to command considerable respect with the public tested in open debate in Parliament, indeed, over the issue of the Cancer Registries and consent to a search, those two issues, where clearly the public identified the Council as being on its side, as it were, against some of the received medical opinion which was still that consent did not really matter.
So I am citing that as an example. I have argued that it is such an important thing that the Council ought itself to take direct responsibility for that because those standards and the amplification and explanation of those standards suffuses everything the Council does. That is one approach which I advocated. That is only possible for the new kind of Council because it is small enough to do that.
Q. One of the disturbing features is that Professor Allen has been pointing to the absence of such standards and the difficulties that they cause throughout the fitness to practise procedures consistently for 70 years

now starting in 1996 and then again in the early part of this year and yet not only are there no standards and criteria and thresholds that are applied of the sort that

she had in mind, but we do not hear of any a firm plans to produce them or, indeed, really the agreement that there is a need for them.
Does that concern you?
A. If that is the case, then it does. I mean, I have set my position out clearly enough. I think that function is fundamental. I understood and this may be a matter of words and presentation that the amplification of what constitutes good practice and what is unacceptable practice of the kind that the Royal Colleges have been doing with the GMC represents work in that direction and it is very important work. So this may be a matter of one side not connecting up with other.
DAME JANET: The Royal College of General Practitioners was the first I think to produce an amplification of Good Medical Practice in the field of its specialty and it is a very useful and helpful booklet, I would think, to doctors but it still does not tell either the doctor or the public when you are likely to have your registration or the doctor is likely to have his registration brought into question, does it?
A. I agree with that and I think that is a piece

of work that now needs to be done but you cannot do that piece of work without doing the first bit.
DAME JANET: I absolutely see that.
A. I think that sort of piece of work is waiting to be done and that is precisely what I referred to in my recent lecture and in chapter XV of the book. That has to

be done now.
That is exactly the same kind of task, incidentally, as our colleagues in the United States and Canada and to some extent in Europe there is a consortium working together there about how this whole business is taken forward. So the United Kingdom is not on its own in this respect.
MISS SWIFT: Can I just come to the new definition which is to applied replacing the concepts of serious professional misconduct and seriously deficient performance. We understand it is to be impairment of fitness to practise to a degree which justifies action on the doctor's registration.
How helpful do you find that definition and how helpful do you think the public will find it?
A. I thought hard about this last night after you aired it yesterday. Of course, I always tended to think in terms of impaired fitness to practise by virtue of misconduct or by virtue of seriously deficient performance

or by virtue of ill health or a combination of those.
I think that those explanatory words are not actually necessary because I do not think fitness to practise on its own would convey to the citizen the nature or, indeed, to doctors the nature of the beast.
I can only offer my thought. I think of it in those terms -- I have said the words, yes.
DAME JANET: But as a lay person I still do not get any ideas of how bad it has to be before fitness to

practise is brought into question. As a doctor, it is like the old adage about an elephant is difficult to describe and easy to recognise. For a doctor it may be easy to recognise when fitness to practise through ill health, performance or conduct is sufficiently serious to bring registration into question, but it is not in the least bit clear to ordinary people, I do not think.

A. That is absolutely right.

DAME JANET: I am not even sure it is terribly clear to doctors either.

A. I think it is not and we have to go back to this historical roots of how this is, which is individual decisions made by individual panels on the basis to some extent of precedent and on the basis of what that group of people thought on that day. I mean, serious professional misconduct -- gosh how circular these arguments have been,

but it is what the Council says it is and it goes to your point exactly. You have to get beyond that point so that people can say, "Oh, that is it."

The best illustration from that is not from conduct and I am reaching into my memory now. If one goes back into the explanatory papers in the setting up of performance procedures, descriptions were given of the kind of situations which would illustrate from hospital practice to the general practice, et cetera, what that was. I do not know whether that is still used but that was certainly there.

One of the things we did not do, which I regret --

and this was entirely with the pressure of all the other things was were happening; imagine reconstructing this whole thing -- I wanted to have law reports, case reports, put on to the web or published regularly. The defence societies do this rather well.
DAME JANET: To a limited audience.
A. Well, I mean, these were all --
DAME J, ANET: Do they go on to the web?
A. The hearings would have all been in the public domain.
DAME JANET: Yours would, yes.
A. Well, the defence societies used anonymised cases but they really are very descriptive and they are very

good. So that was another idea and I hope that -- I mean, I understand Sir Graeme was quite keen on this too that they may return to this but you would have your own view. I have always been impressed by the law reports that one can read in the newspaper giving that kind of synopsis going further than simply the bald announcement of a determination which really does not tell you an awful lot at all. The case does not come alive.
MISS SWIFT: Just going back to the definition for a moment, is there a problem because the definition focuses very definitely on the doctor? Just to illustrate what I mean, an alternative approach to a definition would be to have one which focussed away from the doctor, for example, one limb being something to the effect of whether the doctor posed an actual or potential risk to patients and one would

16 probably have to have at least one other limb to cater for
17 the criminal case and unconnected with patient care which
18 might question whether the doctor's conduct would undermine
19 public confidence in the profession or something of that
20 nature, but just taking the risk to patient limb, would not
21 that sort of definition have the effect that when committees
22 and screeners or case examiners were considering or panels
23 were considering a case, they would have to focus on the
24 patients and the public as opposed to on the doctor himself?
25 A. Yes. I think in my experience of that period,

1 I observed a discernible shift in thinking inside the GMC
2 and inside individual panels. We could all pluck cases and
3 individual situations out of the air but, taking the
4 totality of the thing, I think the Council has moved a long
5 way in the direction that you are describing. It has not
6 gone far enough but that there has been a change there is no
7 doubt and many people who speak to me about this who are
8 members of the public themselves have noticed that. So
9 something has happened.
10 I think that is part of the influence of lay
11 people but I think it is also because there has been a shift
12 in professional opinion. Miss Swift, you drew attention to
13 a particular instance and I could think of instances where
14 that is not the case, but in the round I think that is
15 happening.
16 So the sort of device or expression that you are
17 describing may become more appropriate. It is a new idea
18 and I do not want to give an off-the-cuff opinion about that

but the notion that it is strictly putting the patients' interests first, that that is what comes first, needs to be reflected in some way or other.
The change of heart I can actually pinpoint curiously enough while we are in this Inquiry debated over the GMC's strapline "Protecting Patients, Guiding Doctors", and people who said, "Well, which is it? Which is it?

Which comes first?" Protecting patients.
The unresolved tension in those two things when the Shipman verdict was announced and the debate in the House that followed -- you remember, Madam Chairman, the occasion -- and I had the Council meeting I think it was the week after that, that ended any ambiguity, if ambiguity there had been at that point, to be unequivocally about patient protection.
Now, one can say, "Why has that not all spilled over into subsequent decisions?" My answer to that is some of these things take time to absorb. Why is not the world all signed up to Good Medical Practice? These things time take. The Council changed direction forever at that point.
Q. Just applying a differently focused definition (for example, to an indecent assault case), one of the things that Isobel Allen noticed and, indeed, the Inquiry has seen for itself is that before the PCC there is discussion about such matters as mitigating features and we examined that in the case before lunch the fact the doctor had not been dishonest before and was said to have had a long career with no complaints, the issue of

rehabilitation, the issue of insight, the issue of remorse, all focusing on the doctor and one sees that in other cases in other circumstances.
But if, for example, in the indecent assault

situation, if the panel had to ask itself and apply the test, "Does this doctor present an actual or potential risk to patients", surely there would be only one answer to that and it would be focused, the whole attention would be focused on that test and, yes, of course, mitigation, rehabilitation, insight might inform the view about risk but, nevertheless, that is the difficult question that the panel would have to ask itself.
Do you think that there may be a value in that approach?
A. I think it is well worth exploring. You go to the heart, of course, of the whole point of what I called patient-centered professionalism. It is focused on the patient and the patient's expectations and the patient's interest. It is also tied, I link it to the good name of the profession, as you did. I think that is a radical change of perspective. Finding the ways of giving substance to that, practical substance to that, practical effect to that is one of the challenges that is right here now.
DAME JANET: There is an idea that Miss Swift has come out with. She has had her mind on these matters for a relatively short period of time. Why do you think that it is that after all the length of time the GMC has been thinking about its new procedures and new test for going to

25 a panel and the test that the panel, the new Performance

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1 Assessment Referral Committee which itself was a defensive
2 mechanism which Parliament wholly supported to try and make
3 sure that no doctor would be exposed to these processes
4 unless absolutely necessary but it proved to be a thing to
5 get in the way.
6 Then there are the straight process issues, the
7 delays in getting cases to the point of an assessment being
8 made and I think I have described earlier how one wanted to
9 achieve that, the various steps and loops, the various
10 pieces of process have just proved too difficult, very
11 difficult, to simplify.
12 I could never actually understand how -- various
13 things have to be done, people have been to be notified and
14 so on and so on, but they are creating standards that seem
15 to be difficult to administratively organise and
16 I understand it still is. The success of the instruments
17 and in the cases that you gave what a detailed analysis
18 there is of the doctor's competence and performance and when
19 you take the assessment done at the practice and the tests,
20 I remain full of admiration actually for the team that have
21 put these things together. I know how much care went into
22 this, how much international collaboration there was in
23 bringing these to fruition, led by Dame Lesley. So that
24 piece is pretty solid.
25 Then there is the issue of what you do. We have

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seen some difficulty, subsequently, if there is a referral to the CPP. In the earliest days, and I sat on some of those earliest cases, it was a matter of hearing the evidence, of asking questions about the assessment that had been made, but not of actually trying to second-guess the assessment. We had asked for assessment, we had an assessment.

That process became complicated later, partly under the Crippendorf case which was profoundly unsettling for the Council but also because of the line of questioning which developed through the defence perfectly properly, "Why haven't you looked at complaints", and so on and so forth, and, therefore, a tendency for some panels to, sort of, try and run a second -- almost a second appraisal. I know that that was often very unsettling for the panels having reached a decision.

So there was a question arising therefore. It seemed it became possible that the Committee could be applying a lower threshold than the assessors themselves had which could not be right. I am trying to describe how that could come about.

Then finally, there are the issues about rehabilitation to which you go. The weight given in the proceedings to the rehabilitation of the doctor all stem from the way the procedures were conceived in the late 1980s

and, as I say, the legislation was framed. It is a classic example of what I referred to before as the doctor-orientated approach for all the reasons that we can

understand we were all party to this, et cetera. But that is not quite sufficient now because what happens here is that the decisions about rehabilitation and whether it is practical and what might be done distort, in my opinion, often -- not always -- but can distort the decision about public protection.

I suppose I would add one other thing --

DAME JANET: You mean you go too far down the road --

A. I have seen panels bending over backwards to try and --

DAME JANET: Save the doctor --

A. -- save the doctor. I am not criticising that. I think it is very important not to apply hindsight to this but to remember how it was we started and how it was that Parliament addressed it. It is also important to recognise that that is no longer appropriate and --

DAME JANET: One of the issues, of course, is the resource issue and the doctor himself or herself is a valuable resource if capable of redemption, but the cost of the assessment and the rehabilitation attempts must be enormous.

Is that your understanding of this process?

A. Yes.

Q. Moving to the second part of the process, if we can just go to the second box at the bottom of the page, we have the adjudication process where we have Fitness to Practise Panels who will look at cases divided into conduct, conviction, health, performance and determination which I think relates to determinations by other regulatory

bodies. So fitness to practise panels, non-GMC members, working in public and also subject to the scrutiny and overview of the CHRP which you have already mentioned, in contrast to the investigation process which will not be subject to scrutiny or to potential appeals from the CHRP. Do you see a problem in those two processes, the one very much within the control of the Council, private and not subject to the actions of the CHRP, and the other public, non-Council and with the CHRP watching over it?
A. Well, it depends on how the investigation process is actually developed and operated and in particular the degree of transparency there is about the decision-making and the analysis, the aggregate analysis of decisions made and the explanations given to people and so on and so forth. I mean, I am making an assumption in this that the Council would continue with its stated policy but develop this to have this as a really very transparent

process. That is the first point.
The second point is that I hope we have not lost sight of the exercise of accountability for this part of the process, like the accountability of the rest of the Council, to Parliament. I have not lost sight of the possibility that that would be a logical and proper way of doing it.
I think the third point is the issue of the adjudication panels splendidly open and transparent and accountable as you say to the CHRP, to the power to question its decisions but I am not clear quite what the answer is to the question we discussed earlier how the members of those

panels are sufficiently imbued with the values and the standards that they are actually adjudicating upon. It is not clear to me. When I was there we had not reached that point and I do not know whether the Council has been unable to unravel that yet. We did discuss it. I think it is tied up with some of the things we talked about earlier about the elaboration, the fleshing out in depth and in breadth of the standards --

DAME JANET: Of thresholds and standards.

A. -- and all that, but I would have a concern about that.

MISS SWIFT: One understands that concern but, of course, there is the potential there for scrutiny, for external audit and observation to ensure levels of

consistency and so on, in contrast to the first process which is going to dispose, if the future continues in the way the past has gone, and is going to continue to deal with the vast majority of complaints because it has historically been a small proportion that reaches the PPC and no doubt will continue to be to the Fitness to Practise Panels. What about public perception of a system whereby the majority of complaints continue to be dealt with in private by GMC Council members and committees and beyond getting reasons for an individual decision it is difficult to discover what the process entails and which complaints are going through and complaints are being rejected?

A. In my witness statement and in my paper, recent paper, I referred to the fact that the Council had to

15 become quite a model of transparent accountability.
16 I cannot remember the exact words but a model of good
17 process. One of the things that was certainly clear in my
18 mind as we embarked on this huge overhaul of the fitness to
19 practise procedures is that the principle about transparency
20 and accountability and good explanations to people of why
21 their complaint is not going forward in ways that people can
22 understand would have to be built around those principles,
23 otherwise, it does not matter who it is accountable to, it
24 would not actually make much sense.
25 So it does imply a lot of that new thinking to be

1 translated into deliverables in that process. I do not know
2 how far the GMC has actually got down that road but you will
3 have noticed that I said a principle aim, the first point
4 I made about the future GMC in that paper, it remains the
5 aim that it has to be an open --
6 DAME JANET: Transparent.
7 A. -- transparent organisation. That is what
8 patients and doctors are entitled to expect. My
9 understanding is that just like ordinary, local complaints
10 procedures so many people become reassured or more
11 comfortable if a proper -- if they receiver a proper account
12 and explanation of what has happened.
13 So these seem to me to be absolutely basic
14 principles.
15 MISS SWIFT: Can I just suggest a different, an
16 alternative model. If we just scroll back up, if one had
17 investigation carried out elsewhere, and we have discussed

how that might be managed locally and with the more difficult cases being dealt with by another agency, so if one had preliminary investigations being dealt with outwith the GMC and if one had voluntary health and performance procedures being dealt with at local level and only being referred to the GMC at a time when registration was called into question, one could, in fact, dispense with the whole of the top box, do away with the private procedures and

enter the GMC procedures at a point when registration was in issue and when the only matter in debate was whether action should be taken before a Fitness to Practise Panel and the answer to that would be likely to be yes, because it had been referred for that purpose by a body that knew what it was doing, and then how to dispose of it at the panel. That could be done in public, wholly transparently by non-members of the Council or, indeed, members of the Council but under the present model by non-members of the Council.
Would that not be, from the Council's point of view of presentation to the public, a far more attractive arrangement?
A. I am not sure that it would. I think it is an interesting idea and I have not had time to reflect on it and would want to do so but I do not think I accept the assumption, the inference, that the Council is incapable under any circumstances of operating an effective investigations machinery. It ought to be as capable as anybody else. You could argue, well, it has not shown that

21 so far and I could argue that actually I could show you the
22 results from some very effective investigations indeed, but
23 I think there is something here about the Council being able
24 to investigate cases where a breach of its own standards is
25 an issue. It is a very fundamental point. I would wonder

1 also how the investigating body would itself understand the
2 same basic standards and values questions.
3 I could see this being fragmented to the point of
4 being very unsatisfactory. So that is a kind of negative
5 answer to your postulate. If one heard more about it and
6 perhaps in the seminars there will be an opportunity to
7 develop these ideas but the whole of what I say is
8 predicated from a public perception point of view on the
9 fact that the Council will make a thoroughly professional
10 job of carrying out investigations, as Merrison originally
11 envisaged that kind of unit, and equally that the issues of
12 transparency and explanation and so on and so forth was
13 dealt with satisfactorily. That would be an absolute
14 requirement.
15 DAME JANET: Do you see any advantage in the GMC
16 not having to deal with the sifting of complaints and
17 concerns that were never going to get anywhere near a public
18 hearing.
19 A. Yes, I do. Mr Henderson in his address to
20 you, which you kindly sent to me, raised the question of the
21 single portal and that came up yesterday.
22 I think that is an attractive idea without having
23 worked it through. I have raised that on behalf of the

Council with two secretaries of state both Mr Milburn and his predecessor Frank Dobson and I know that Sir Graeme is

keen to develop this too. There is something about simplifying things for people if they choose to use it.

DAME JANET: You cannot compel them to go down one particular route as opposed to another but you can only encourage and educate and help and put things right -- steer them, yes.

A. When I listened to the discussion yesterday, I think Mr Nicholls touched on it but the Government has just despatched, in my opinion, one of the best mechanisms that the citizen had which was the Community Health Council. Some of them were effective, some of them less so, but they were all capable. The best ones provided exactly the kind of service that we are talking about.

When I was at an ADMAR(?) meeting recently reviewing how the new things are working, they are working less effectively than the things they have actually replaced. So there was something about the independent mindedness of the really good Community Health Council Secretary who could be that open door and be sufficiently independent to be able to put things firmly to a Health Authority or to say to the GMC, "Be the patient's friend as well".

So just remind ourselves that we have just lost something quite valuable.

DAME JANET: And PALS does not replace that --

A. No.
DAME JANET: -- in any sense, does it?
A. No.
MISS SWIFT: I asked you about public perception a moment ago in relation to the new procedures. I would just like to ask you about it, a matter that was raised yesterday which is in a case where there has been an inquest where a Coroner has criticised a doctor or doctors or perhaps, more particularly, an Independent Review Panel where there had been clinical assessors or some decision of the Health Service Ombudsman, what do you feel about public perception if a case of that sort where there has been that background and adverse findings is not aired in public by the GMC?
A. I think that is quite a difficult situation and in the context in which we have been speaking, Miss Swift, I would imagine that those cases would have to be heard by a panel in future for the very reasons that they would have gone through various processes beforehand and really they would have to have a public hearing.
Q. You would think that was desirable, would you?
A. Yes. I mean, the whole movement, has it not, has been towards taking more cases towards an airing, an examination, your words, a Committee decision of some kind and away from idiosyncratic personal decision-making. That

I think is a wholly welcome process. I think it is much to be desired. If you had a situation in which a doctor has been criticised, clearly in the public mind if not elsewhere, that could well raise questions about the doctor's registration. Well, those matters should be put to rest in the public mind by taking either, reassuring or not, but by a proper process of examination.
DAME JANET: Similarly with cases of conviction, which are by definition in the public domain. It seems to me that once a doctor has been convicted of a criminal offence, that it is unsatisfactory if the same section of the public that was interested in the fact of conviction and was aware of that is then not aware of the way in which it has been handled by the GMC.
A. I think it goes back, Madam Chairman, to the discussion about dishonesty and the other things. It is this question of perception. How can you be convicted and not be guilty of serious professional misconduct is what a lay person, I suspect, would think. If that is the starting point it seems to me a sensible one, then I think the Council has to be able to address that in future. That, of course, was my whole point about broadening this basis because, of course, people might say, "Well, what actually does that amount to?"
"Oh, I see, it was going through a speed

camera."
The public response to that might be quite different from theft.

DAME JANET: I was not actually suggesting that offences of speeding would come into that category but there was one very --

A. It is just an example.

DAME JANET: Quite. There was one very good example we looked at of a doctor who was convicted of drugs offences which were of sufficient severity for him to be sent to the Crown Court to be dealt with and the matter then went to the GMC. Of course, there were a number of colleagues and people in his area who were aware of his conviction and one doctor subsequently wrote to the GMC saying, "This man's been convicted and the GMC does not appear to be doing anything" or I think the expression he used was, "Takes no notice". In fact, the GMC was doing something, had in fact put the doctor into the health procedures. Whether that was a good decision or not, I pass no comment. That doctor who wrote in did not know what was happening and he had a genuine interest, a proper interest in my view, in knowing how his own professional body was dealing with that doctor.

A. I think you touch on another major thing which we are only, sort of, halfway into and that is actually how

the Council communicates with the profession. I have made the point again a fortnight ago about the profession, never mind just the GMC, needing to find a new language of engagement, of explanation, of communication with the public and that Dr Foster experience is a good example of a body accustomed to speaking and presenting information in

a digestible and understandable way can be very successful. My profession has not mastered that. It has never had to. That is not a criticism. It has to learn that now and the GMC certainly has to. It has to get to grips with that. It is not just talking to the profession, it is primarily talking to the public. So it has to be able to get its message over.

DAME JANET: The profession is an important part of its own public.

A. Absolutely. It is one of its key stakeholders.

MISS SWIFT: Do you think that there is any real prospect of either the GMC or the profession being able to communicate with the public whilst it appears the profession and medical members within the GMC are divided on the issues?

A. Yes, I think there is a difficulty and that is precisely the difficulty that I was addressing in that lecture. It was the central difficulty. The solutions do

not lie, in my opinion, with individual doctors. They just cannot influence the system. So we are down to the question of how the central bodies of the profession, particularly those with an interest and a responsibility, for standards of practice, actually do get their act together and arrive at a consensus position and, if at all possible, bringing the public into this, taking the public with them about precisely these matters.

That, of course, was precisely why I was

urging that it is decision time for the profession to get these things together. It requires a level of co-operation, examination, analysis, and so forth. It is about saying this matters. How the profession is perceived and is, is doctoring safe and effective matters, we have to take it seriously and that was my main point.
We can regulate until the cows come home. If the profession does not do that, the results will always be minimalist. So it is absolutely crucial that the profession gets this and everybody will work at this, I hope.
I sincerely hope.
I think optimistically -- I have to have some belief in this -- that there is now greater awareness, there is now a move in the direction of patient-centered care that we were referring to before but that is where the matter rests. That was the purpose of some of the seminars that we

are about to take forward in the New Year in the north and through the King's Fund. We are going to have a major initiative there. The question is how -- so which medical schools, which Royal Colleges, which specialist societies will go with this kind of thinking, will go public with it, will give leadership to their members with it, set the direction right?
I think it would help the GMC enormously if it heard from its constituents, particularly the other standard setters, what their expectations are. They need to be proactive in this too.
DAME JANET: The Royal College of General

Practitioners I think has made its position clear.
A. It has, it has and it is that sort of --
I mean, this is co-operative --
DAME JANET: Leadership.
A. It is about -- this is about leadership, yes.
MISS SWIFT: Madam Chairman, I have no further questions for Sir Donald. There is just one matter that Mr Henderson has asked me to bring to your attention and it relates to the quotation from Dr Korlipara's evidence that I gave earlier. He would wish me to put it in context so I wonder if I might just do. So I think he thinks it is important that Sir Donald hears this also.
I might begin at a little earlier in the

transcript and I am now on page 40, line 18, Dr Korlipara began:
"My view at the moment, I have some views and I would like to present them to you, it is this: the GMC traditionally has received complaints. It has not instigated complaints other than if it has seen the press or in some public domain. But, by and large, complaints have been referred to it and it is looked at the complaints and upon the merit of those complaints, after-careful analysis, come to a conclusion whether there are any issues that would indicate such standards, either in conduct or in performance, that fall so seriously short of acceptable Good Medical Practice that further action on the doctor's registration should be considered. If the answer is yes, the Inquiry proceeds to the further steps. If the answer is

16 no, and it is an isolated complaint which of itself does not
17 raise the spectre, we assume that in the case of National
18 Health Service patients, which are either managed by the
19 PCTs or its predecessors or the Hospital Trust, they do have
20 a duty and they will be doing their duty of informing us if
21 they had any concerns unprompted.
22 "Returning to the repeated question put to me as
23 whether the GMC should have initiated enquiries of its own
24 of the PCT or the Hospital Trust when the isolated complaint
25 of itself does not really amount to any serious nature,

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1 functioning, is it doing what we expect it, if not, why not,
2 and so on and so forth.
3 DAME JANET: This through the Joint Select
4 Committee you have in mind, principally?
5 A. Through the Council itself and then there is
6 the second layer --
7 DAME JANET: Is in Parliament?
8 A. Exactly.
9 DAME JANET: Last night after we rose, Dr Esmail
10 and I were discussing how the Council might scrutinise the
11 decisions of its own Fitness to Practise Panels which of
12 course is going to be at one remove from, in that they are
13 not going to be Council members. Its control will have to
14 be through education and persuasion as to principles rather
15 than any control over the decisions that are to be made and
16 we discussed one or two ideas about how that might be done.
17 Have you given any thought to that because it does
18 seem to me very important from the public perception angle
19 that the GMC gets this right?
20 A. At a purely operational level --
21 DAME JANET: I meant --

A. -- one of the things that has happened is we did introduce operating standards for the various arms of fitness to practise, you know, getting things done on time.
DAME JANET: Service delivery.

25

A. Service delivery.
DAME JANET: I was thinking more of the quality of the actual decisions made and the observance by committees over which -- panels over which the GMC has no direct control of the policy lines that they wish to promulgate; in other words, the kind of doctors, the kind of conduct, the kind of incompetence or poor performance that will actually lead to a particular kind of sanction being imposed or will not and will lead to supportive measures, because as I think it was Sir Graeme pointed out yesterday, the GMC has no means of appealing a decision of a panel that it does not approve of -- and I cannot at the moment see how that could be sensibly arranged -- but that does not mean to say they cannot do anything about it.
I wondered if you had given any thought to that problem for the future, where the GMC is in a much more attenuated position in respect of those very important from the public point of view, those panel decisions.
A. I was going to offer that as another, different kind of example. I think it is very fundamental. I think the work that has been started through Good Medical Practice and is being developed by the Colleges with the GMC fleshing out the detail of what is and what is not acceptable practice has to be taken forward. I see that as

25 a mainline activity of the Council itself. Indeed, I argued

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1 in my book that that actually ought to be the prime function
2 now. Clarity about standards and breaches of the standards.
3 If that work is taken forward in that way, then
4 particularly with the panels adjudicating at one remove,
5 then I would have thought that the Council now needed to
6 have a mechanism whereby it was scrutinising every decision
7 that is made on a systematic kind of way and testing those
8 decisions against the standards it says are necessary.
9 DAME JANET: And if dissatisfied with its own
10 panels, educating?
11 A. Then it has to educate, to alert, to change.
12 There are a number of things that might be appropriate in
13 different circumstances, but the function of being able to
14 test the extent to which there is compliance with its own
15 stated standards seems to me absolutely fundamental.
16 DAME JANET: That is a view that we were
17 expressing to one another last evening when we rose. I am
18 grateful to you for expressing your view.
19 A. I think if we can get that bit clear, that
20 would be extremely helpful because a whole lot of other
21 things would fall into place. It would also help the
22 Council, incidentally, in its function of prosecuting, of
23 bringing cases because it would then have a much, much
24 clearer idea of where --
25 DAME JANET: Where it stood?

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A. -- where it stood, what it was trying to do and it could articulate that to the public and the profession in a way that it cannot quite do now. We must not lose sight of the fact, going back to Mr Lissack's public presentation point, prior to 1995 when Good Medical Practice came on to the agenda you could not say any of those things. All you had was negative behaviour as expressed in the Blue Book.

I was very, very struck, Mr Lissack, by the extent to which when Good Medical Practice was published the relief in the profession, "Thank goodness you have told us what you mean by good practice", equally the relief among members of the public and employer authorities, "Thank goodness you have said what it was that we are supposed to be expecting. Actually that happens to coincide with what we are looking for too". So there is something well-founded about that which needs to be built on.

The completion of the loop is reality, the testing of reality against the standards has got to be an integral part of the process. That is why the GMC has also, in my opinion, got to be good at assessment because in all these -- well, most of these mechanisms it is going to rely on assessment to be able to make those judgments, make those determinations.

DAME JANET: Thank you.

You have written several times -- and we can go back to looking at them if we need to -- as long ago as 1997 that, in your judgment, professional self-regulation

underpins the concept of an independent profession. Those are your words from an article that you wrote. Is that still your belief?

A. Yes. I have to go back I think one step before that. Medicine I think like the law is, at the end of the day, decisions are judgments. Certainly in medicine in diagnosis and in treatment doctors take decisions on normally less than perfect information and, as I have described elsewhere, I can conceive of no system in which it would be possible on a day-to-day basis to scrutinise every decision that doctors make.

So it is absolutely critical to the public and the public interest that doctors conduct themselves honestly, conscientiously, competently and that the system is designed to try and ensure as best as possible that that is what actually happens. The only way that I know of that you can be reasonably sure of getting that is by making sure that the profession itself is well and truly locked into the process; it has a sense of ownership at least of part of that.

So that is the rationale behind my thinking and the thinking of many others. It is not peculiar to myself.

But I back it by two others' points. To the best of my knowledge in countries where that kind of professionally-led standards-driven approach does not apply, where the regulator is much more of a mechanistic, holder of the list or administrator in a way of various regulatory processes, the degree of detachment between profession and regulator is

remarkable and the extent to which the regulator can actually influence affairs is, in my experience, quite limited. So there is a structural issue there.
The second point is that the profession does respect, whatever it may say, when it gets irritated with it, perceives it doing things the profession does not quite agree with, nevertheless at end of the day it reckons decisions made by the GMC because it is of itself the profession is locked into that process. That is what brings about cultural identity and cohesion and, at the end of the day, the greater likelihood that doctors will abide by the rules that are deemed to be necessary.
DAME JANET: Do you think the GMC has a closer relationship now with doctors than it had? It has been said in evidence that certainly a few years ago the GMC was regarded as being very remote, a dreadful police force in the sky, as it were, that if you could keep out of their way altogether that was devoutly to be wished.
Has that changed? Is there a greater interchange?

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A. Profoundly so, profoundly so. The change is brought about, Madam Chairman, not through fitness to practise but through the standard-setting activities and, of course, revalidation is about to touch every doctor's life. So, for better or worse, every doctor is aware of the Council now, aware of the parameters of good practice in a way that five years ago we were a long, long way from that point.
DAME JANET: When Mr Lissack has finished -- I do

not know whether he is going to touch on revalidation -- I would like to ask you one or two more questions about revalidation. I will leave Mr Lissack to finish.

MR LISSACK: Thank you very much.

Can I just deal with this point and then leave Madam Chairman with a clean field and I shall try and finish quite quickly.

Your answers that you have just given, if I may say so, with the greatest of respect, Sir Donald, prove the problem, do they not, that five minutes ago you articulated the principles which should inform the independent process, that it should be open, fair, act in the public interest, be there to protect patient and be perceived as doing so.

Then you went on to say in your second point that -- and forgive me turning away just to read the screen: "The second point is that the profession does

respect whatever it may say when it gets irritated when it perceives it doing things that the profession does not quite agree with nevertheless, at the end of the day, it reckons decision made by the GMC because it is of itself the profession is locked into its process. That is what brings about cultural identity and cohesion. At the end of the day, the greater likelihood is that the doctors will abide by the rules that are deemed to be necessary."

How can you have within the same organisation both the independent adjudicating arm of the profession that satisfies the principles of fairness, openness, wins public confidence and so forth, yet is still of itself insofar as

13 doctors may judge it enforcing cultural cohesion and
14 underpinning the willingness of doctors to abide by its
15 rules? How can the same body properly fulfil both objects?
16 A. You mentioned specifically adjudication there
17 and you know that my position, not the Council's ultimate
18 position but my own position, was that we would be better
19 served by separating fully the adjudication process so that
20 the Council responsible for standard-setting, responsible
21 for education, at the end of the day seeing that all the
22 pieces of the system in training and so on and so forth
23 worked properly, embedded the standards properly, where
24 breaches occur investigating those fully thoroughly and
25 competently and bringing action to put things right.

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1 merits?
2 A. Yes.
3 DAME JANET: Available to either side.
4 A. I am making the assumption, following
5 Mr Lissack's line of questioning, I am making the assumption
6 that in five years' time shall we say the GMC has a very,
7 very much clearer picture with the public of what good
8 practice is, of what the departures from that are and what
9 the sanctions should be in various circumstances.
10 DAME JANET: I hope that that will be so. One of
11 the reasons that I doubt the advisability of a new layer of
12 if appeals is that historically the courts, the Privy
13 Council in effect, have said the GMC themselves are the best
14 judges of whether a doctor should be struck-off or not. If
15 one is asking for a review of the merits as opposed to
16 a review of the law, whether the decision is lawful, it
17 seems to me likely that the courts are going to say, "This
18 is really a matter for the GMC. They have set up their

panel, they educate their panel, they choose their panel day set out the principles for that panel".
A. I think there are unresolved practical issues about how to make this work. In my mind --
DAME JANET: You would like to see --
A. In my mind, the clearest way would have been to separate off the adjudication from the bringing of the

case because then, quite clearly, the GMC would have set out its stall as to what should happen, what it thought about this case and, if it was dissatisfied with the results of the independent adjudication, after all they would have to be against its standards because those are the professional standards for registration, then I think it could be a very strong-looking GMC from a public point of view because they are able to say, "This is not good enough; something should be done about this".
I just acknowledge that this is probably not the right place to be trying to think these sort of conceptual issues through. I just acknowledge that there is --
DAME JANET: There is a problem there and you would like to see a resolution of it?
A. Yes, I would.
MR LISSACK: Sir Donald, you have already answered my last question which was to reinforce your view as to the separation of adjudication so I have no further questions. I am extremely grateful to you not only for your time today but all that you have written before today over the years. Thank you very much.

MR MCDERMOTT: Madam Chairman, in his written statement Sir Donald was asked to deal with certain issues arising out of the Renate Overton case including the question of what the outcome might have been. That is not

is all about will.
DAME JANET: Yes and, of course, it will be said resources. One of the possible methods of saving on resources is, as it seems to me, to have where there is membership by assessment of the RCGP and were the Royal College to develop a refresher mechanism, which I understand they are working on, would you then be happy with that as a revalidation substitute?
A. Yes. I mean, I have said in the recent lecture that I would have liked to have seen the Royal Colleges, all of them --
DAME JANET: Setting the standards for revalidation, yes.
A. An optimal standard, not the least we can get away with but what the citizen would recognise and accept as good practice and assist their members in keeping up-to-date and demonstrating that their knowledge and skills are up-to-date, bring in the evidence from clinical governance as required and effectively make their memberships or fellowships in good standing, a statement of what good practice is. If I were the GMC I would accept that --
DAME JANET: As an alternative --
A. -- as an alternative, particularly if I could be sure that the College mechanisms were right but as I have argued you would simply assess that in saying that the GMC

assesses a university now.
DAME JANET: Which I do not think would be very difficult.
A. I think many of the colleges would actually welcome that.
DAME JANET: Respond to that, yes.
A. I think the other point, if I make may --
DAME JANET: Of course --
A. -- we did not mention standard and I do think that we have to bring to an end the situation whereby the entry standard of practice is for some doctors less than the standard required by the college in the MRCGP. I gave you and Miss Swift the reference to Professor Stuart Murray's work. The fact of the matter is that there is something like, 10 per cent variation in standard across the country from one Deanery for another. So what you get in one Deanery is not necessarily the same as in another. And, of course, there is something like a 20 per cent difference between the pass rate in the MRCGP and summative assessment.
DAME JANET: For entry, yes.
A. So we have to bring that ambiguity, it seems to me, to an end by unequivocally placing the standard round the MRCGP examination test. If that were done, I would then argue that you simply then calibrate revalidation against

that standard.
DAME JANET: Yes.
A. Any ordinary person would say, "Is that not rather obvious? I thought that is what you would be doing anyway".
DAME JANET: I floated the idea the other day that one would start with the summative assessment at year 1 on the basis that it might be asking rather go lot to ask everybody to be brought up to the standard of membership by assessment but that the first revalidation should be based upon the membership standard that one would have to undertake say five years after entry to general practice and that, thereafter, a recalibration or refreshment against that standard would suffice, either as revalidation or as an alternative to the other routes to revalidation. That is slightly less ambitious than what you were proposing a moment ago --
A. But I could see that as a transitional phenomenon if it was clearly seen from the outset as just that --
DAME JANET: To be transitional?
A. -- to be transitional, but the alien point, shall we say in three years point was membership level and, "We are giving you notice and you can all get the chance to get there".

DAME JANET: It should not be too difficult to improve to that extent in say three years or even less so in five.

A. I think it could be done in three years if we put our minds to it. It is all about putting our minds to it. The methods are all there. The various instruments that the Royal College has, if you take the Scottish and the other things, are capable of being rejigged, repieced together if that were the policy intention. What is missing at the minute, I think, is the policy intention. I am clear where I stand.

DAME JANET: Thank you very much. Mr Henderson?

Examined by MR HENDERSON

Q. Thank you. Let us stick with revalidation, Sir Donald, if we may since it is fresh in mind. I am not going to debate models of revalidation with you. There is clearly potentially more than one model. Would you agree with me that whichever model is chosen, it should be cost-effective, cost-effective in the sense particularly of producing proper revalidation which is reliable and not taking improper amounts of doctors or other people's time?

A. Yes. I would apply that to any system of assessment.

Q. Indeed. I do not think we have the precise

hourly or daily calculation of what would have been involved in the piloted model but there is no doubt, is there, that it would have been intensive in terms of use of doctors' hours -- maybe 40 doctors' hours, full days' hours per day throughout the year?

A. Do you mean in terms of carrying out the

assessments or being assessed?
Q. Indeed, the triumvirate with the layman in the chair?
A. Yes, there is an opportunity cost.
Q. That leaves out of account, of course, in the other -- not loss of time but taking of time for the doctors themselves to make sure that they are producing product which is fit for purpose. That, of course, is an appropriate part of clinical governance necessary there in any event to raise standards. So that is a cost which ought to be incurred in any event, in your judgment?
A. Yes, it is part of quality practice.
Q. In answer to Madam Chairman's question as to whether or not the Royal College of General Practitioners refresher course, which is presently under consideration, might be a substitute for revalidation I think the substance of your answer was it could be an alternative. Could I just ask you this: first of all, have I understood the substance of your answer?

A. Yes. Substitute I did not mean. I think the doctor can choose the form of evidence that he or she presents. If the college has a system on offer which the practitioner chooses to use and the GMC finds that acceptable, that seems to me a sensible alternative.
Q. If the GMC were to do it -- and it leads me into a separate topic I want to ask you about concerned revalidation -- then would you agree with me that it would be necessary for the GMC to quality assure that process to

make sure that it was a suitable alternative or a suitable method of establishing the licensure of the doctor?
A. Yes.
Q. So you would still want to see the GMC in its regulatory function discharging that overseeing role and making sure that whatever evidence was being produced under whatever system the system itself was a satisfactory quality assure, d system?
A. One of the anxieties I have had has been the extent to which the GMC would itself operate an effective system of quality assuring the process in any of the managed care systems. I just believe that is fundamental. It has been a part of the model since it was very first devised. I think that the GMC has to taker considerable responsibility itself for making sure that if it is accepting evidence from others, that it knows what it is

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Do you see revalidation being a continuum involving clinical governance as something which should prevent a sliding back?
A. Yes. I see revalidation effectively carried out in the way that we have all been discussing as really both galvanising change and providing the measure of transparency in the system which would enable people to see that it did not slide backwards and part of the problem has been the lack of transparency in the system. So I think that is all very important.
Q. The answer which you gave me before that one referred to professional assistance leading to the bringing of everybody into the fold as well as management. Could you help, please, in answering this other question from

Madam Chairman:
"I can see how that might work in the hospital service which is a truly managed environment. I am less sure how I can see it will work in general practice which is not a managed environment."
A. Yes, I think I have to go back, Madam Chairman, to the teaching practice system which, in a sense, was a semi-managed environment, in this sense: you had a university postgraduate organisation which had its contracting teaching practices but which took a strong interest in both the standards of practice and standards of

training and the standards of professional development, and took the best of them, the best of the organisations took a strongly proactive line in making these things work effectively. I mean, I call that managed in a very strong kind of way.
I think -- I have reported it in my evidence -- the most striking thing is that in the best of these, South-West England, for example, the Thames Valley, for example, I am thinking about Leicester too here more recently, there have been two characteristics. Firstly, it has been possible to aspire to good standards to get the membership standard generally accepted, for example, and see it is a positive thing to do.
Secondly that compliance with effective standards has been enhanced by the willingness of the managing organisation to help people get there and make sure that it happens. So the two I think go together.

18 DAME JANET: Yes, but the managing organisation in
19 the training practice you are describing the supervision
20 management provided by a university. That only applies in
21 something like 30/33 per cent of practices in England and
22 Wales. That is right, is it not?
23 A. That is right.
24 DAME JANET: My perception at the moment -- and it
25 comes largely from evidence given by employees of PCTs -- is

1 that they do not see themselves as having anything
2 approaching managerial authority over doctors and, indeed,
3 we are about to embark on a new general practice
4 practitioners' contract in April which, of course, does for
5 some doctors provide a relationship of employer and employee
6 but leaving them aside, there are still a large number of
7 doctors who, even under the new contract, although they will
8 be providing a lot of information about their practices and
9 on that will depend their earnings, they are still not being
10 managed. They cannot be told to do things differently or
11 better. Indeed, there is not much of a mechanism in the PCT
12 to encourage them to do things better.
13 A. I agree with that and I accept that and
14 I think that is part of the challenge. I think that the
15 PCTs as they are now are actually relatively weak
16 organisations.
17 DAME JANET: They are brand new.
18 A. They are new. I make no judgment other than
19 the fact that they have a very difficult job to do.
20 But on the other hand, what do we mean by

"managed"? Telling people what to do or making sure that
things work? I go back to --
DAME JANET: Knowing what is happening and where
it is not satisfactory, correcting it.
A. So I go back to my --

DAME JANET: And also laying out how things should
be done. Those are the fundamental -- I mean, I am not a
management consultant and I have no aspiration to be.
A. Those are the basic element.
DAME JANET: I would think so.
A. Those are the basic elements that you have
found in the best teaching organisations but those are the
basic elements that, for example, makes Northumberland or
the South-West of England work well.
The issue is not what the characteristics are but
how you transport those characteristics into other health
authorities. I think that has to be done. I do not accept
that doctors will automatically resist that. On the
contrary. I mean, all the evidence is that where you have
PCTs that function exactly as you are describing, if they
have got their style right and their processes right and
their relationships right, you have a very, very positive
relationship.
DAME JANET: It would obviously be very
satisfactory if that were to come about but what concerned
me was the reliance by the GMC on appraisal and clinical
governance for the purposes of revalidation, where the
theory behind this was, "We are working in a managed

environment and, therefore, we have the ability to impart and receive through clear channels of management".

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Now I am assuming, without knowing because hospitals are outside my terms of reference, that that is possible in a hospital environment which I can see is truly managed. I am concerned about the prospect of revalidation relying on the assumption that those channels of management are working freely and satisfactorily in general practice because that is not the impression that I have had.
A. I can only agree with you but then this brings one to the point of the GMC's role in satisfying -- it is back to the quality assurance point. It does need to satisfy itself that the people it is going to appoint as agents --
DAME JANET: Are actually --
A. -- are actually capable of delivering the --
DAME JANET: But you see the attitude at the moment of the GMC appears to be, "Well we are entitled to assume that the PCTs will do this and do it well and properly because that is their statutory duty and if they do not do it right CHI will be on to them and make sure that they do. So it is all right for us the GMC to stand back and rely upon that".
Now I know they do not say that they are going to stand back, they say that they are going to quality assure, but I, at the moment, have difficulty in seeing how they can do that, given the nature of the relationship between the

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PCT and, the GMS doctor and their own resources and the relationships that operates at the present time.
A. I entirely accept that and you are touching upon part of my concerns too. It depends to a substantial degree on the extent to which the GMC is prepared to be proactive and assertive about what it actually expects the system to deliver.
DAME JANET: Time is relatively short, is it not, if revalidation is to be brought in in 2005?
A. December 2000 --
DAME JANET: December 2005?
A. In December the year 2000. It came to my attention that as a result of the discussions going on between the NHS and the BMA over appraisal for consultants that the GMC would be denied access to the folders and any means in fact of verifying, of making sure the system worked.
I met Sir Liam Donaldson, the Chief Medical Officer, to say how concerned I was about this and that this could not possibly be and that led to an exchange in which he said to me, "So what would the GMC's position be if actually you were not able to verify if, in fact, it is true that the arrangements being worked out by the management the employers, would exclude any form of verification?" I said to him at the time, "We would disallow your process of

appraisal. You could use it for your management purposes that is your business as the employer but clearly if we could not verify its quality, we could not recognise it and that is what we would do."

I followed that through with a letter which I indicated he could make public if he wished so that perhaps that could be changed, which it was. Imagine a similar circumstance now: the GMC may well be saying to a PCT where it is known that funny appraisals are coming forward, "If you continue in that vein we will not actually be able to accept any of the statements that you are putting forward unless you change your practices. What you do as far as your management role is your business and the NHS's business but it does require a proactive" --

DAME JANET: It is a bit of a difficult stance in a sense for the GMC to take because if the PCT said, "I am very sorry we do not have the resources to do it, either in terms of money or people, to do things any better, what are you going to do about it, GMC?" They are going to be left with 100 unvalidated, unrevalidated doctors.

A. Yes, I can see that and that is why earlier I have mentioned the importance of having a robust dialogue about this, about getting from A to B, as it were, of closing the gap because you see I would argue that if the PCT was not in possession of the kind of information needed

for revalidation, it is not actually functioning properly as a PCT anyway, your very point that you made earlier, Madam Chairman, that this organisation, this PCT, knows what

its contractors are doing, knows what's the results are like that, in fact, they are behaving well as contractors.

DAME JANET: Yes.

MR HENDERSON: You wanted to be able to see and referred to a document which I was able to identify as being part of the pilot study. It is page 20 of the transcript of that Friday. I think it has now been scanned in. Could we try -- and, Madam Chairman, this is the annex to the revalidation piloting exercise stage 2 at WB5900070.

DAME JANET: This is Mr Brearley's --

MR HENDERSON: It is the annex to Mr Brearley's statement. I have been given the reference _WB5700059^ as the first page of this document. I have not got it as scanned in.

DAME JANET: 00059.

MR HENDERSON: Could we scan forward in that 11-pages, please, _WB5700070^. Back one page if you would, please, _WB5700069^ to table one.

Sir Donald, am I right in thinking that this is what you had in mind it is the first page of an annex to the second pilot study and just so you can just see on, could you now scroll forward so that you see table 2 _WB5700070^

and just scroll on again just to make sure I have identified what you had in mind.

Is that what you did have in mind, Sir Donald, as earlier work which showed the sort of information which ought to be available and upon which you would assume that a doctor's revalidation ought to be able to established by

way of evidence?
A. Yes, it is. I mean, this is the kind of detail that I thought would help to build up the picture of the doctor at work.
Q. I am not going to take Madam Chairman's time or other's time because it has now been scanned in and is available going through it. It condescends to very considerable detail. I am going to go on to another topic but thank you for identifying it.
I just want to make sure I have understood that it is your philosophy and fundamental belief that the local process is at the heart of revalidation, it is, therefore, vital that it is quality assured but it is to be local rather than some national or superimposed regime?
A. The value of the local process lies in the fact that the starting point would be arrangements inside a general practice for internal quality assurance which would generate the kind of information on a regular basis that we are talking about here.

The second strength of it and the potential strength of linking it to appraisal was that every year there would be an opportunity to bring this evidence together and not only reflect on that but to be sure that things were working well and then every five years the GMC would have the opportunity directly of signing that off. That contrasts with the position in many countries where with recertification or revalidation the licensing authority takes a five-yearly slice, a cross-section.

From a patients' point of view, potentially this system is very, very much -- likely to be very, very much more robust because it is a continuous process and I think Mr Scott and Sir Graeme describe that yesterday. So it is well worth the effort of trying to get this to work because the gains to the patients are huge.

Q. Bearing that in mind, it does inevitably, as Dame Janet asked you this question at the foot of page 31 in the unredacted transcript and I quote her, I hope, exactly: "It looks as if there is a great deal of delegation there." You went on first of all to talk about the Scottish model and then you compared it with the situation with graduates coming from our medical schools and said this:

"The GMC does not examine any student graduating but it satisfies itself by quite a robust process that the

form of examinations which it expects the system of external peer review of examiners which it exists on and so on and so forth is producing graduates of a consistent and sure quality. I see a direct comparison with that."

If Madam Chairman is going to be able to take some comfort from or place reliance upon those words, can you help us with just a little bit more what "... which it insists on and so on and so forth" so that we complete the picture, please, Sir Donald?

A. I draw the distinction in delegating. Delegating is the word. We stick to the universities for the moment. The GMC does not assess medical student who are

qualifying. It accepts a bit of paper called the degree, but that degree -- within that degree there is a whole process of education and assessment underneath it which the Council has taken responsibility for and satisfies itself not once but regularly that the system is working properly.
DAME JANET: And does so, however, on an individual university or individual university medical school basis?
A. Yes. So that is the principle. If you applied the principle to health authorities, Trusts, undertaking this kind of work, the Council would need, it seems to me, to adopt exactly the same position. It would need to satisfy itself, Trust by Trust, that the

arrangements were as they were claimed to be if the doctor was seeking to rely on that part of the system it would have to make the effort to do that.
My point also has been that it cannot delegate that responsibility of assuring itself to CHI or anybody else. That is where the buck stops. That is where it has to be sure.
DAME JANET: That is its own added value.
A. And it is a huge added value, if it gets that right.
MR HENDERSON: Thank you. I want to come now to the concern which Madam Chairman and you and others have expressed about the lack of experience and critical mass of investigatory ability in PCTs.
As I understood a number of your answers -- for

the note they are at pages 41, 44 and in 48 of the transcript -- you would answer that with a regional approach rather than a national approach; that is right, is it not?
A. Yes. I qualified my answer in the sense that there is no structure at the moment but I related it to the work done by the old regional health authorities and the Directors of Public Health where there was actually quite a good system.
Q. Could you just assist us, please, with your thinking which you said you have not completed but clearly

you will have been pondering on it for the last week and a bit with your thinking as to how best the investigative powers of local matters of concern and local complaints might be structured at a regional level?
A. One of the possibilities is some sort of consortium of Trusts which come together to share expertise and to carry out the investigation of complaints in the first instance -- and I think it is quite interesting to see how the NCAA, which has a different line of investigation to the GMC, it is a much more formative kind of process, is working with some of the Trusts to start this kind of process working.
DAME JANET: They are certainly helping Trusts with performance assessment and that does seem to be working quite well in that you have a sort of supervision by the NCAA and what the PCT can manage on its own direction, but they actually carry out the assessment very often themselves under the guidance of the NCAA and the NCAA comes in in

19 cases that are more difficult, serious or problematical.
20 That seems to me to be a good arrangement. What
21 concerns me is how one applies this to cases that are
22 concerns, reports, complaints, whistle-blowing that is not
23 just a question of assessing a doctor's performance, there
24 are all sorts of other things that have to be looked at of
25 a more truly investigatory as opposed to assessment nature.

1 It is that kind of function that it seems to me at the
2 moment PCTs are extremely weak on, by and large, and the
3 NCAA does not officially have powers to do and does not
4 strictly speaking employ people to do it either at the
5 moment, although both of those matters perhaps could be
6 altered.
7 I was wondering about the NCAA having extended
8 powers in this regard so that they could give advice on the
9 investigative technique to apply to a particular case and
10 perhaps a resource existing at regional or Strategic Health
11 Authority level that was available to the PCT, because, of
12 course, at the moment the executive power to do all these
13 things resides with the PCT and plainly that is right and
14 sensible and must be built on.
15 Have you had any ideas? You say the idea of
16 a group of Trusts -- well, yes SHA or, if not convenient,
17 a smaller group, I suppose, you could have.
18 A. The, sort of, going back to the regional sort
19 of idea, system, there are, what, eight strategic health
20 authorities?
21 DAME JANET: I think so, yes.

22 A. Let us leave the Strategic Health Authority on
23 one side because of the.
24 MR MCDERMOTT: Either 28 or 32, madam.
25 DAME JANET: It is as many as that?

1 A. Certainly let us leave them on one side then,
2 forgive me.
3 But I can imagine a grouping of perhaps eight or
4 ten consortia in the --
5 DAME JANET: Eight or ten PCTs?
6 A. Eight or ten consortia of PCTs throughout the
7 country. In a sense replicating or doing many of the things
8 that the NCAA does now and the kind of investigative
9 functions that you are describing which is the business of
10 any trust in the first instance. We are simply talking
11 about how that could be done better. So I can imagine the
12 consortium of around eight of those in the country.
13 Miss Swift I thought was developing something along that
14 kind of line. That, of course, would enable it to have
15 a relationship with the regulator, with the GMC.
16 This whole thing would become very
17 much more manageable, clearer lines of communication
18 as to what should be handled locally, what should be
19 handed over, at what appropriate time and so on and
20 so forth. These are not formed ideas but the point
21 about critical mass of expertise seems to me to be
22 absolutely fundamental. I think I would have picked
23 a structuring along those kind of lines, where the
24 local PCT, retaining all its authority as the

25 contracting agency, nevertheless was able to say,

1 "Well, we will get the help of the consortium to
2 work this problem out or to investigate that part
3 for us" --
4 DAME JANET: Or to assign us a person?
5 A. Whatever it is that is decided to help to do
6 that and at the same time be clear when it has problems
7 either of a conduct or a performance kind that it needs to
8 refer to the GMC for further investigation and/or action.
9 There are too many pieces at the minute.
10 DAME JANET: That was one of the reasons why I was
11 anxious to avoid proposing the setting-up of any new
12 structure because it does seem to me that in terms of
13 structures we ought to be looking forward to a reduction
14 rather than an increase.
15 A. I can see, for instance, that were that to
16 happen I could see the need for the NCAA disappearing.
17 I could see that. I could imagine that happening. I have
18 discussed that with some of the assessors and they can see
19 that too. If that function --
20 DAME JANET: That they would operate regionally
21 rather than centrally?
22 A. Yes. That is not a million miles away from
23 the position the GMC took, as Mr Henderson will know, in
24 response to the Donaldson paper on -- what was the title of
25 the paper again? It was about poorly performing doctors.

MR HENDERSON: Supporting doctors: protecting patients, I think it was.
A. The proposition there, the position the Council took at that time was precisely a regional grouping only the chosen instrument were the regional post-graduate organisations, as I mentioned the other day, because there is a regional structure and an infrastructure already there which would have been capable of being adapt and deployed to that end if one chose to use it. I think that is actually still another valid option.
DAME JANET: Yes, except that if one wants to include the investigation of events as opposed to the assessment of performance, then one develops -- one would be extending the function of a postgraduate Deanery or postgraduate organisation too far, I think.
A. I can quite see the difficulties of that. I entirely accept that point.
DAME JANET: An assessment of performance is quite close, is it not, to the Deanery?
A. And the rehabilitation if one is deciding to do that. So there is something to be built on there, it seems to me, but I had in mind only the fact that there was an existing regional body with an infrastructure which would be capable of being adapted if one chose to do so. I am not advocating that but simply saying such a thing exists.

DAME JANET: It is sensible to look at the

existing structures to see how they could be adapted rather than setting up new ones which just leads to complexity.
A. So if one followed that through then, whatever configuration one eventually came up, with the notion of good investigation locally to begin with, decisions locally if that is appropriate, then a much more interactive formative relationship with the GMC as to how these things are taken forward and the GMC which would be much more in touch with emerging problems even though it may not --
DAME JANET: Be seized of the actual case.
A. Exactly. If one linked that over with the kind of analysis that ought to flow from the revalidation issues, you can begin to see what --
DAME JANET: How it would hang together --
A. -- how it might look and hang together and how much more information we might have of a usable practical kind that could be made very public, how reassuring to the public all that might be.
DAME JANET: I was encouraged yesterday by what Sir Graeme and Mr Scott said about the flow of information in both directions between Trusts and the GMC. It seems to me that is very important.
A. I absolutely agreed with them about that and I think that is quite fundamental.

I think the other point, going back to the lecture, a point I made there which Mr Lissack brought forward this morning, it is the extent to which, in collaboration and making the various parts of the system

work, we recognise that we are embarking on something quite new and that we are talking about a measure of co-operation and active co-ordination and working together, teamworking -- nobody has travelled this road before --

DAME JANET: It is fairly recent--

A. -- it is quite vital.

DAME JANET: It is fairly recently that the GMC have recognised themselves as part of a regulatory system rather than the regulatory system.

A. Yes.

DAME JANET: That is a big step.

A. What the GMC must not now do is say, "Because we are part of the system we do not have any responsibility in the thing, it is the system." It has to take responsibility for its part of the system.

MR HENDERSON: You used these words a few moments ago:

"Then a much more interactive formative relationship with the GMC as to how these things are taken forward and the GMC would be much more in touch with emerging problems ..." and then the sentence was

interrupted.

From your own personal knowledge as chairing the Professional Conduct Committee in relation to the Bristol Babies case, the GMC and its solicitors, Field Fisher Waterhouse, have very considerable decades of experience of investigating even very, very major cases. That one involved the collection together of not less than 40 babies'

outcomes over a four and a half year period. That is a resource which potentially is available to any such regional structure, to guide them and help them.

A. Yes. I think I am glad you raised that again, Mr Henderson, because I can say this, Madam Chairman, without reservation for, as you know, because I chaired that hearing I had no part and no knowledge of the investigation and I can only record how impressed I was about the thoroughness and care with which that -- and professionalism, sheer knowledge and skill, that that investigation was carried out.

It was professionalism on all sides, the doctors' side as well, but the investigation itself it was very sophisticated involving very complex systems, very complex care. You would not get it more complicated than that and I thought that the GMC acquitted itself splendidly on that. If it can do that, it can do most things.

So the question is how we build on that --

DAME JANET: I must confess I had not seen a role for the GMC in providing investigatory expertise beyond its own immediate functions. I think at the moment my view is that that would be a step very much in the future because they need to extend their own investigatory functions in a different direction for the present, in other words, to investigate before they make their minds up rather than after.

A. They have to get that piece of the process

changed and that piece of the process right.
DAME JANET: It will mean much more investigation than has taken place because it means that you are going to investigate cases that do not then in the event ever go for a panel hearing because having investigated them you appreciate that that is not necessary.
A. But if we take Mr Henderson's point and if we look ahead, in my mind's eye certainly I see the development, on the one hand, of a body of people both lay and medical who are really expert in the assessment business. They may work partly locally they may work partly for the GMC --
DAME JANET: Not just assessment investigation as well as assessment.
A. Sorry, may I just finish my point. A body of

expertise in that area matched by a body of expertise in the investigation of the kind of situations that we are talking about and you could imagine, if we had our eight regional foci and the GMC, the sort of flow of expertise and information but also skill developing. I think this could be a very exciting development and I think that fits closely with the suggestion from Mr Henderson.
MR HENDERSON: Sir Donald, I am going to leave that topic now and go to the separate topic of a GMC problem of disconnect between the Fitness to Practise Panels where it has no membership and its present lack of any power to appeal its decisions and various questions.
You have already said in answer to questions today

that this is an issue which needs to be explored. Given your position that you would have wished wholly to separate adjudication from the other roles of the GMC, logically it would seem, I would suggest, that you would be strongly inclined to favour some way in which the GMC could ensure that there is no disconnect and could ensure that its standards are carried into real effect in Fitness to Practise Panels.
A. Yes.
Q. In the absence of a power of some form of review of those panels because of non-participation in them, do you see a potential difficulty for the GMC in trying to

ensure that its judgment about doctors and what they should and should not be doing is carried into full and proper effect?
A. Yes, I do but I would add two other points that may be of help for the GMC in this regard. Firstly, Madam Chairman, I return to your point about education and training and feedback but really I go also to the point I made about analysis and the point of the systematic analysis, review analysis of the results, the publication of those results in other words the GMC's review of the performance of those panels collectively could be very, very powerful indeed. I cannot believe that were process to be carried out by the GMC -- and it could do it now if it chose to -- it could have a quite striking effect on the behaviour of the panels because it would concentrate their minds on what it is that the regulator said was important and what

17 appeared to be less important.
18 DAME JANET: Really are you saying that you think
19 that that could be as effective as a judicial appeal process
20 which --
21 A. It would have all that potential and, of
22 course, it would be not confined to cases where you felt
23 that you had to -- where the decision was so way off that
24 you wanted to go to a court --
25 DAME JANET: To get the actual decision reversed

1 we prove what there is following the lines that the GMC is
2 already developing, if that is helpful.
3 DAME JANET: Thank you.
4 MR HENDERSON: Madam Chairman, of course, you
5 heard from Mr Townsend that the criminal standard obtains in
6 the General Dental Council.
7 DAME JANET: I had forgotten that, yes.
8 MR HENDERSON: Chartered accountants and the joint
9 disciplinary scheme apply the civil standard.
10 DAME JANET: Solicitors?
11 MR HENDERSON: Solicitors, the civil standard.
12 DAME JANET: The Bar?
13 MR HENDERSON: Now, it is a long time since I sat
14 on one of those panels and somebody else is going to be more
15 up-to-date. I do not know.
16 DAME JANET: I think it is the civil standard. It
17 is absurd that there are so many of us here and we do not
18 know!
19 MR HENDERSON: We will at least be able to find it
20 out.
21 DAME JANET: Mr Eccles says it is quite

22 reassuring!
23 A. Of course, that could be said to be
24 complacence!
25 MR HENDERSON: Let us move on. The question which

1 I would like to ask you next concerns the role of the Royal
2 Colleges.
3 I think there may be a material difference between
4 your position and the one that I am going to put but I may
5 have misunderstood. The GMC's position is that the general
6 standards must be the GMC's to set and to devise for the
7 totality of the profession. There we are on common ground,
8 I believe.
9 A. Yes.
10 Q. That it is for the Royal Colleges insofar as
11 they deem it appropriate to do so to then build on those
12 basic and fundamental standards which the GMC has set out
13 particularly in the document for which you are largely
14 responsible, and in relation to the particular specialties
15 to spell out for the specialties greater detail which might
16 apply to those specialties.
17 A. Yes.
18 Q. Can I take it, therefore, that if and insofar
19 as we have thought at any stage from what you have said that
20 you were saying that the Royal Colleges should set the
21 standards and that the GMC should then fill in the detail,
22 that would be a misapprehension?
23 A. That is completely the wrong way round. Yes,
24 that would be a misapprehension. I had clearly not

25 expressed myself clearly enough.

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1 If we go to _HP0205266^ again, we then see that at
2 the end of March there were about 65 cases in the screening
3 processes which had been identified as potential performance
4 cases but which had not entered the procedures and in most
5 of those cases, the Office was making further enquiries with
6 a view to assisting the screeners in deciding whether or not
7 the case should be referred into the performance procedures.
8 Then there is mention of concern at the length of
9 time which it was taking during 1999 for cases referred to
10 enter the procedures where this was appropriate. This is
11 then the time taken for cases to actually enter the
12 procedures, not once they had entered them. Two main
13 reasons had been identified: pressure of work in the office
14 and also lack of evidence given by health authorities,
15 health boards and Trusts and some time had to be taken to
16 gather the necessary evidence.
17 I want to discuss timing within the performance
18 procedures shortly, but what about the time that it takes
19 now for a case to get into your procedures. Has the problem
20 that we see here identified been resolved?
21 A. I think it has. Neil Marshall will be able to
22 tell you that in screening they have service standards and
23 in most cases they have to progress that case within four
24 months and by progress, I mean referral to the PPC or
25 referral to the Performance Assessment section.

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1 So the history that we have seen there certainly

is not the case now. We are much quicker at referring cases into the process.

Q. You may not have direct knowledge of this but you may be able to get some idea from the papers that you see: do you get the impression that the local organisations (the PCTs and Hospital Trusts) are more organised about gathering their information and sending a greater amount of information to the GMC in the first place?

A. I think that is correct. I think when the performance procedures were introduced in July 1997, I do not think anyone was that sure what should and should not be provided and there was a period in which, as you can see from the figures, not many cases were referred to us because, of course, the legislation was not retrospective. So it was a case of the local processes gathering information and then sending it to the GMC.

Q. Then we can see at paragraph 30 that there were plans to deal with this first of all by the recruitment of additional staff and, secondly, by improving communications with NHS bodies. Then there is some detail of the improved communication in an attempt to speed things up within the office. Then there is the observation that that has led to more effective communications and more rapid resolution of difficulties over obtaining evidence.

Within the Performance Section itself, do you have a lot of communication with referring bodies or does that tend to take place rather more at the screening stage?

A. I think it happens in both sections. I think

in screening they have a considerable amount of contact with organisations like the NCAA and PCTs and from my own experience as Head of Performance I have had discussions with people within the NCAA and PCTs. I am often asked to give talks about the process of Performance Assessment -- frequently asked -- and I am happy to do that. So there is a lot of contact about what we do and how we do it.

DAME JANET: Yes, but that is contact on an educational basis rather than on an individual case basis.

A. We have it on an individual case basis too.

DAME JANET: As well, right.

A. Yes.

MISS SWIFT: Then we see the figures for the, Assessment Referral Committee, seven cases having been referred in the almost three year period up to March 2000. In each case the Committee held an oral hearing which the doctor attended and in all but one of the cases, the Committee decided the doctor should be required to undergo an assessment.

Then there is detail of the remaining case where it was decided that the evidence that the doctor's

performance had been unsatisfactory after 1st July 1997 was not sufficient to justify requiring an assessment because in those early days, I think you just mentioned there was the problem of the cut-off date of 1st July.

It is recorded that the doctors had complied with the ARC requirements where appropriate.

Then paragraph 36, eight assessments had been

completed and reports provided and others were in the pipeline. Then there is a breakdown of the specialties of those doctors and then five of the eight had gone to the CPP, the sixth had undergone remedial training and the seventh had been found not seriously deficient and the two remaining cases were still under consideration. It was expected that there would be another 30 to 40 assessments by the end of 2000.

Obviously, there was a fairly slow start on assessments no doubt for a number of reasons, but there were not the cases in the beginning. About how many assessments does the section do now, do you know?

A. We did 67 assessments in 2002 and I suspect we will do a similar number by the end of this year.

Q. Indeed, if we go down to 42, we see feedback and an annual conference is referred to. Then at 43 in the CPP at performance hearings there had been five cases and in each case, the CPP had found that the doctor's professional

performance had been seriously deficient and suspended the doctor's registration for a period of 12 months and then there are some details given about the way in which the CPP approaches its decisions.

If we can just scroll down, there is a part at the bottom here: trends in cases and issues and the distinct rise in the number of cases referred as recorded and the future is uncertain, although there could be significant increases. It was expected that the number of Committee hearings would increase significantly and then at

paragraph 50 we see that 54 of the 66 cases so far referred had come from the NHS Authority, Trust or Health Board, four from Postgraduate Deans, tutors or advisers. Are those a source of referrals with which you are familiar?

A. From experience I think I have seen one or two.

Q. But not a very frequent occurrence?

A. No.

Q. And then three from other medical colleagues, two from members of the public and three from other sources and it is said that it is not surprising that the great majority have come from those who would be likely to have knowledge of the doctor's general performance, and you have told us that that remains the position now.