RESPONSE OF THE ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH
GOOD DOCTORS / SAFER PATIENTS

General comments
The College is generally supportive of the aims of the document but we do have some significant concerns about some aspects of the proposals. We are all aware that in the past there has been reluctance in the medical profession to constructively criticise colleagues. In future, we must make it the norm to inform colleagues of concerns and help them address them without fear of the consequences. A key principle to keep in mind throughout is being as fair to the doctor as the patient, and this should equate with how society treats all its members. Until this happens, no amount of system change will improve matters.

Despite our support for the general principles, the recommendations that are made do not always seem to match the preceding summary of evidence and discussion. For example, it is acknowledged in discussion that the process of NHS appraisal may be either formative or summative yet recommendation 18 does not acknowledge appraisal as formative at all, but clearly regards it as assessing performance against generic standards.

We would also point out that many of the medical problems that occur are related to team and system failures and these have not been adequately dealt with in the paper. The interaction of different personalities also plays a very important role and the significance of this is lost in this document which concentrates very much more on individual performance.

As a general point, many recommendations have been made without a clear sense of which are the priorities and how doctors' time is going to be found and funded for these important activities. We also have concerns generally about the overall cost of the proposals and how they will be financed.

Clearly a lot of work will be needed to translate the principles into a practical framework. We feel that a carefully phased approach will be needed to make such a major series of changes in the context of the complexities of clinical and medical practice and performance.

Comments re specific recommendations
A. Recommendations 1 – 15: To ensure effective and fair fitness to practise procedures

Recommendation 1:
In adjudicating upon concerns about a doctor's performance, health or conduct, the standard of proof should be the civil standard rather than the criminal standard.

We are concerned about reducing the burden of proof from criminal to civil. We acknowledge that from the patient perspective the civil standard of proof offers some assurance that poorly performing doctors will be addressed. However, from the paediatric point of view, this downgrading of standards of evidence risks exposing the medical profession, and in particular paediatricians, to possible miscarriages of justice. Our duty of care is to the patient (the child), and because of our statutory role
in child protection, paediatricians’ actions may sometimes bring them into conflict with the child’s parents, carers or guardians. A large proportion of those involved in child protection work have had complaints made against them, with only a tiny minority being upheld. This can lead to dissatisfaction with the paediatrician’s actions and even questions about a paediatrician’s performance in a way that is not replicated for other medical specialists. These issues are not necessarily those of medical care, medical ethics or confidentiality, though all of these have specific differences when paediatrics is compared with other sub-specialties. Any system that increases the risk that paediatricians’ proper actions and activities will be interrupted or misinterpreted will be to the detriment of their professional practice and the health and welfare of their child patients.

Therefore, it might be considered that for fitness to practice cases, the GMC should use the criminal standard of proof before a doctor is to be suspended for a protracted period (as punishment) or struck off, as the person concerned will lose their job and livelihood. For temporary restrictions to practice associated with retraining, the civil standard of proof could be used to arrive at this recommendation.

**Recommendation 2:**

The General Medical Council’s role in investigating concerns or complaints about a doctor’s standards of care or conduct should be extended to a local level by the creation of medically qualified licensed General Medical Council affiliates within each organisation (or group of organisations) providing healthcare.

**Recommendation 3:**

General Medical Council affiliates should be authorised to deal with some fitness to practice cases locally (according to detailed guidelines and definitions) and refer cases at the more severe end of the spectrum to the General Medical Council centrally. Affiliates should have the power to agree a ‘recorded concern’ (but not to impose sanctions affecting registration). The affiliate should inform a doctor’s employer or contracting organisation and any complainant when a ‘recorded concern’ is accepted. ‘Recorded concerns’ should be reported to the General Medical Council centrally for collation.

At first sight the creation of GMC affiliate within each organisation providing health care might seem a way of dealing locally with some fitness to practice issues, and enabling unwarranted cases to be rejected prior to any GMC involvement. However, the proposal raises several important questions, and we have concerns about its overall feasibility.

The role of these individuals and how they would work in practice needs to be clarified. The GMC affiliate would be a challenging role requiring a doctor with tact, discretion, determination and the unanimous respect of colleagues. The role is not likely to be popular, and may well attract the wrong individuals into it.

Doctors are unlikely to accept a recorded concern being put against them and will be keen to resist any such move. This will mean that local affiliates would need to be closely involved with Trust complaints departments, and to conduct themselves, their investigations and activities in such a way that the process cannot be challenged. This implies training and considerable local expertise and infrastructure to assist an affiliate and ensure that there is uniform approach nationally. This ongoing support and the funding for training and assessment of the affiliates represents a major
tranche of work, and the mechanisms for this are not adequately addressed in the proposals.

We would also point out that the Medical Director could do much of what is expected of the affiliate. The difference is that the affiliate will have an external accountability to the GMC, not just to the Trust. However, this could be established for Medical Directors through a similar mechanism to the current position of the Trust Clinical Tutor – who has joint accountability to the Trust CEO and the Dean, and generally manages this dual accountability effectively.

Whilst a local GMC affiliate may be able to investigate matters related to generic skills or misconduct, it is difficult to see how an affiliate outside the specialist area of the doctor would be able to handle issues relating to clinical practice of an individual. Would there be a regional specialist affiliate too who would also assist in these matters?

Recommendation 4:

Where a doctor does not accept a recommendation from a General Medical Council affiliate that a ‘recorded concern’ be entered on the Medical Register, they will automatically be referred to the General Medical Council centrally.

This recommendation suggests that recorded concerns will not just be a matter of secure confidential information but would be potentially open to public scrutiny. Many of the complaints made against paediatricians are in the context of cases of disputed child protection. In these circumstances a paediatrician may be undertaking their statutory duties in a proper manner, but a complaint can still result. Unless the GMC affiliate appointed locally has special knowledge of paediatrics, children’s health or child protection issues, they might not be in a position to reach a judgement without significant input from other professionals, particularly those in paediatrics.

Recommendation 5:

Each General Medical Council affiliate should be paired with a member of the public, who should be trained in regulatory and disciplinary procedures. Together, they should operate as part of a wider team within each organisation. This team should include existing complaints management staff and should have administrative support.

The principle that the GMC affiliate should be paired with a member of the public so that they do not work in isolation is a sound one. However it is unclear as to whether both will have authority to determine the outcome or whether the lay member will simply be there to advise and offer an opinion and therefore the authority rests with the affiliate. The lay member of the public would need significant knowledge and understanding to be able to voice an independent view from that of the medically qualified affiliate who in turn needs to be independent of the doctor being assessed.

Recommendation 6:

A national committee should routinely review all ‘recorded concerns’ entered on the Medical Register. This committee should be able to discuss individual cases with the relevant General Medical Council affiliate if necessary and, in
exceptional circumstances, may choose to refer a practitioner for further assessment or investigation.

There is some attempt at an external review of the work of the affiliates outlined in this recommendation, that is, a national committee. However, this is an indirect assessment of one facet of their performance and will it be feasible in practice? For example, how much local detail will the national committee need in reviewing cases? It will very much depend upon the way the information is recorded as to whether this will be a sensitive enough process to ensure that affiliates are performing appropriately and that a ‘record of concern’ is set at an appropriate level. Overall these recommendations place a great deal of responsibility on these individuals.

Recommendation 7:

Each healthcare organisation should identify, and bring to the attention of the relevant General Medical Council affiliate, those complaints that raise concerns about the performance or conduct of a specific doctor.

Recommendation 8:

Patients and their representatives should be given the option of lodging complaints about services and individuals in primary care, either at the level of the practice, or at the level of the primary care trust. Such arrangements should be publicised widely in surgeries and within patient information resources.

Recommendation 9:

General Medical Council affiliates, together with the complaints management staff of the organisation, should offer to meet with individual complainants (where appropriate) to address their concerns about specific doctors, explaining any actions taken, or the reasons for apparent inaction. Individual doctors may be required to attend such conflict resolution meetings at the discretion of the General Medical Council affiliate.

This effectively makes GMC affiliates part of the complaints management structure. Meetings with complainants are often difficult territory and a GMC affiliate faced with vociferous and persistent complainants will be under considerable pressure to undertake action to appease them, potentially including revealing confidential details about a doctor or agreeing to “record” a concern.

It is unclear how individual doctors would be compelled to attend conflict resolution meetings or what sanctions would be imposed should they decline to do so. As many of those meetings might be anticipated to be difficult, uncomfortable or even threatening for the doctor in question this contingency must be addressed.

Recommendation 10:

The General Medical Council should establish rigorous training, accreditation and audit for affiliates, along with comprehensive arrangements for their support in carrying out these functions.
This recommendation suggests there will be a rigorous ‘training accreditation and audit’ of these individuals which will be pivotal to the success of the whole process but no detail is provided in the document. There is also little mention in the document about the assessment of the affiliates, but an objective assessment of their performance and ability to undertake the role will be required.

**Recommendation 11:**

In serious fitness to practice cases, which cannot be dealt with by local regulatory action, investigation and assessment should be carried out by the General Medical Council but formal adjudication should be undertaken by a separate and independent tribunal (with legal, medical and lay representation). Doctors and the General Medical Council should have the right of appeal against the decision of the independent tribunal to the High Court.

This suggests that, in serious fitness to practice cases, adjudication should be undertaken by a body external to the GMC. In principle, this does separate the role of ‘prosecutor’ and ‘judge’. However, it is unclear how this body will be formed, trained and regulated.

**Recommendation 12:**

The Healthcare Commission and the Parliamentary and Health Service Ombudsman should be able to require the General Medical Council to assess or investigate an individual doctor’s performance, health or conduct. These bodies should also be authorised to investigate and bring doctors before the independent tribunal in exceptional circumstances.

It is unclear how in practice this recommendation would work. We believe this is important and should be set out clearly. However, the precise lines of communication and responsibility have not been defined. It is open to the possibility for vexatious complainants to persecute a doctor through local investigation, after which if the result is deemed unsatisfactory, through the ombudsman etc. Safeguards would need to be in place to prevent such an occurrence.

This, in tandem with other recommendations, increases the multiple jeopardy that doctors currently face, where complainants may go through a series of steps (local complaints, litigation, Health Service Ombudsman, Health Care Commission, complaint to the GMC etc), which has to be faced by the doctor at each stage. It might be better if a simpler system were developed which did not involve so many steps.

**Recommendation 13:**

During its assessment of a practitioner whose fitness to practice has been called into question, the General Medical Council should make full use of the expertise of the National Clinical Assessment Service.

We fully endorse this recommendation that the services of NCAS should be part of this process. If there is a prima facie case to answer, it may be preferable for the investigative process to be devolved to NCAS and the regulatory role left to the GMC based upon NCAS findings. The basic rule that one is innocent until proven guilty should continue to apply to doctors.
Recommendation 14:

The National Clinical Assessment Service should further develop methodologies for the assessment of practitioners with mental health and addiction problems. The NHS should commission a specialised addiction treatment service.

We support this but accept this is a difficult area because of the unwillingness of Occupational Health and the doctors themselves to share information. Doctors with bipolar disorder can be a particular risk to patients, and if their supervisors / colleagues do not know this, then they can be seen as being awkward and difficult. Similarly, doctors with severe depression can be perceived as lazy. Others with mild Asperger's or obsessive, compulsive disorders can also be seen as difficult. Addiction is an equally serious problem and this is an area which needs clarification.

Recommendation 15:

In managing cases where fitness to practice has been called into question but which cannot be dealt with locally through a 'recorded concern', the General Medical Council centrally should have the power to specify packages of rehabilitation and conditions on practice, following a comprehensive assessment. Cases should be brought before the independent tribunal only where a practitioner is uncooperative, where such measures have failed to remove serious risk to patients, or where specified serious misconduct has occurred. Arrangements for making interim orders concerning a registrant's practice where urgent action is required should remain in place. The Council for Healthcare Regulatory Excellence should review the handling of such cases, and refer for adjudication before the independent tribunal any for which it is considered that more serious sanctions were appropriate.

No comment.

B. Recommendations 16 – 37: To Assure and Improve the Quality of Practice

Recommendation 16:

A clear, unambiguous set of standards should be created for generic medical practice, set jointly by the General Medical Council and the (Postgraduate) Medical Education and Training Board, in partnership with patient representatives and the public. These standards should be adopted by the General Medical Council and made widely available. They should incorporate the concept of professionalism and should be placed in the contracts of all doctors.

Recommendation 17:

A clear and unambiguous set of standards should be set for each area of specialist medical practice. This work should be undertaken by the medical Royal Colleges and specialist associations, with the input of patient representatives, led by the Academy of Medical Royal Colleges.
We would strongly support this recommendation. It would align well with our competency framework which clearly sets out standards for each level of training and for each subspecialty area. Progression from one stage to another being the basis of CPD, is a principle underpinning the whole framework. We recognise that in some areas of practice some competences gained during training will be lost and others will be gained.

Using the same methodology we used in the development of the competency frameworks it would be easy to derive consistent and coherent standards against which an individual may be assessed for revalidation. In addition, assessment blueprints will inform which assessment methods would be most appropriate to select for that assessment. The whole curriculum framework is sufficiently flexible for Trusts and individuals to define which standards are relevant for a particular area of clinical practice and could be derived as part of the appraisal process to meet recommendation 19.

**Recommendation 18:**

**The process of NHS appraisal should be standardised and regularly audited, and should in the future make explicit judgements about performance against the generic standards, as contained within the doctor's contract.**

The main body of the report depicts appraisal as a largely formative process, however the model described in recommendation 18 is explicitly summative. There is therefore a significant dislocation of meaning within the document.

NHS appraisal is acknowledged in the discussion section of the CMO’s document to be regarded differently by different bodies. In practice, however, appraisal is a formative process that allows the progress of a practitioner to be documented year on year. Recommendation 18 suggests that appraisal should be standardised, regularly audited and should make explicit judgments about performance against generic standards. This is a very different model to the one underway in most NHS Trusts and does not acknowledge the formative element that is important to the best appraisal. This summative approach has potentially difficult implications for standard setting and failure to meet targets. Nevertheless, we support strengthening of appraisal and failure to meet standards must be addressed.

**Recommendation 19:**

**The role of the General Medical Council to set the content of the medical undergraduate curriculum and to inspect and approve medical schools should be transferred to the Postgraduate Medical Education and Training Board (whose name should be changed accordingly).**

There is little evidence to date that PMETB, which has the responsibility for the curriculum for foundation programme and specialty training, has demonstrated much evidence of encouraging or ensuring linkages between the two. In practice it has derived processes for quality assurance and quality control of the Foundation programme that have been developed entirely separate for those for specialty training. One model might be to keep the responsibility under the regulator (i.e. the GMC), with the option for it to delegate delivery to PMETB as appropriate.
Recommendation 20:

Any organisation contracting with doctors to provide services to NHS patients should ensure that all doctors have successfully completed an accredited assessment of English language proficiency in the context of clinical practice. The content of this examination should be approved by the (Postgraduate) Medical Education and Training Board.

We support this recommendation. There should be a mechanism to ensure that doctors, wherever they come from and when English is not their first language, are not only familiar with written English and medical terminology but also spoken and common colloquial English.

Recommendation 21:

A formal opinion should be sought in Europe as to the legality of the introduction of a standardised national examination as a requirement for initial registration with the General Medical Council (in addition to the clinical and other examinations necessary to obtain a university medical school degree within the European Economic Area). This examination would include assessment of both English language proficiency and clinical knowledge, and would be taken by all doctors seeking provisional or full registration, irrespective of their place of primary qualification.

This is likely to result in rather more consistency than would necessarily occur from PMETB taking over the role of setting curricula and inspections. Having a National examination would provide a strong demonstration that the standards reached at the entry of postgraduate training are the same. At present we have little idea whether a graduate from an EU Medical School has covered the same curriculum and is of the same standard as those training in the UK.

Recommendation 22:

A formal opinion should be sought in Europe as to the legality of the introduction of a standardised national examination as a requirement for initial registration with the General Medical Council (in addition to the clinical and other examinations necessary to obtain a university medical school degree within the European Economic Area). This examination would include assessment of both English language proficiency and clinical knowledge, and would be taken by all doctors seeking provisional or full registration, irrespective of their place of primary qualification.

It is not clear what the role of PLAB will be in the future. Trainees wishing to enter training will need to demonstrate that they have competences at the precise level of entry and standards of assessment, and tools with which to make these assessments will have been defined. It is difficult to see how PLAB, which has not been mapped to the curriculum and which is not part of the blue printing exercise, fits into this.
Recommendation 23:
Medical students should be awarded 'student registration' with the General Medical Council, and medical schools should have a General Medical Council affiliate upon their staff who should operate fitness to practice systems in parallel with those in place for registered doctors.

No comment.

Recommendation 24:
All doctors wishing to work in the United Kingdom should be registered with a healthcare organisation that has a General Medical Council affiliate. In addition, all agencies involved in the placement of locum doctors should be registered for this purpose with the Healthcare Commission and be subject to the standards operated by it.

No comment.

Recommendation 25:
At the conclusion of every locum appointment, the contracting organisation should be required to make a brief standardised return to the relevant General Medical Council affiliate, providing feedback on performance and any concerns.

We do not believe this is practical. By the very nature of their practice many short term locums work single night shifts or occasional weekend shifts making very detailed assessment of their performance often difficult to achieve. However, some thought needs to be given to how we ensure that locum doctors have the sameassessment of performance as substantive posts, although this needs to be done over a rather longer time frame than a single post.

One solution might be for locums to carry a log book, updated at every workplace, and have a periodical interview with a GMC affiliate, local to where they live, who should have the power to randomly check with individual employers.

Recommendation 26:
The process of revalidation will have two components: first, for all doctors, the renewal of a doctor's licence to practice and therefore their right to remain on the Medical Register ('re-licensure'); secondly, for those doctors on the specialist or GP registers, 're-certification' and the right to remain on these registers. The emphasis in both elements should be a positive affirmation of the doctor's entitlement to practice, not simply the apparent absence of concerns.

We support this recognition of the need for life-long learning and the need to demonstrate that performance is fit for the role that an individual is undertaking.

However, these proposals imply that a specialist will have two separate hurdles to cross, with twice the bureaucracy. Perhaps re-certification as a specialist could be assumed to include re-licensure?
During a doctor’s career, their responsibilities may shift from their original job plan owing to advances in medicine, changes in their career path, or alterations in their responsibility. Some thought may need to be given about how the process of re-certification could incorporate and accommodate this shift of responsibilities. The Academy of Medical Royal Colleges’ Directors of Continuing Professional Development Sub-Committee (DoCPD), is already addressing the issue of how further ‘Post-CCT Credentials’ can be obtained so that a consultant or career doctor can augment their current skills in a recognised way.

The interval and the areas that should be assessed will require careful consideration and more detailed work. For example, data tends to suggest that doctors early in their career have problems with communication and professional skills. However, later in their career it is often a lack of knowledge that is the problem for doctors in difficulty. With changes in training programmes this balance may change but work may need to be done in order to identify which areas of practice it will be most important to focus on at different stages of a doctor’s career and these may be different when they are working in different subspecialty areas.

Recommendation 27:

As doctors approach retirement, they should be invited to a review with their General Medical Council affiliate, where registrant and affiliate should decide together whether a further five-year period of re-licensure is desirable and appropriate. The idea of maintaining a register of retired doctors (to extend beyond such a five-year period) should be considered in more depth: a working group should be established to examine this area and to establish which professional privileges should be permissible for those on such a register. In particular, the safety and desirability of the proposal to allow retired doctors to issue private prescriptions for a limited and defined range of medicines should be considered.

The purpose of maintaining a register of retired doctors needs to be clarified. Does this have implications beyond enabling doctors who have retired from the NHS to continue working in private practice? Allowing retired doctors to issue private prescriptions should be considered with respect to the issue of doctors prescribing to their own families.

What is meant by approaching retirement (55, 60, 65, 65+)? This needs to be worked out more carefully. There would be the ability to modify assessment processes so that those competences certified could be restricted to certain areas which would be appropriate to post retirement practice.

Recommendation 28:

The re-licensing process should be based on the revised system of NHS appraisal and any concerns known to the General Medical Council affiliate. Necessary information should be collated by the local General Medical Council affiliate and presented jointly as a confirmatory statement to a statutory clinical governance and patient safety committee by the chief executive officer of the healthcare organisation and the General Medical Council affiliate. The chairman of this committee should then submit a formal list of recommendations to the General Medical Council centrally.
We are concerned about the legal position of the GMC affiliate. Will this person be at risk of finding themselves in Court for failure to identify a doctor at risk or vice versa? This post will need appropriate indemnity for what is potentially a very high profile and very important role in the quality assurance of a local service.

Recommendation 29:

When a practitioner changes employer or contracting organisation between relicensure cycles, the previous General Medical Council affiliate should provide a standardised record outlining the practitioner’s current position in relation to the elements contributing to relicensure. In addition to any other professional references sought, prospective employers should ensure that such a record is obtained in a timely fashion.

It is essential that information should transfer from one place of employment to another. This currently does not happen and doctors in difficulty are often found to have had concerns much earlier. If Royal Medical Colleges are to be responsible for holding all this information they will be in a very good position to flag up at an early stage those doctors who might have causes for concern.

Recommendation 30:

An independent organisation should be commissioned to design and administer the 360-degree feedback exercise required for appraisal and licence renewal.

Various 360 degree feedback exercises are underway in some, but by no means all, Trusts. Evidence for 360 degree feedback tools is stronger for formative than summative assessment (i.e. it is more helpful in guiding the practitioner’s further Continuing Professional Development than in showing whether they are a good doctor or a bad doctor). Projects are already underway to validate a core series of questions for 360 degree feedback on doctors, based on ‘Good Medical Practice’ from the GMC, augmented by a series of speciality-derived questions.

Our College has considerable experience with 360 degree feedback for trainees and we will be involved in the AoMRC’s existing 360° appraisal pilot study for consultants. We support this recommendation.

Recommendation 31:

Specialist certification should be renewed at regular intervals of no longer than five years. This process should rely upon membership of, or association with, the relevant medical Royal College, and renewal should be based upon a comprehensive assessment against the standards set by that college. Renewal of certification should be contingent upon the submission of a positive statement of assurance by that college. Independent scrutiny will be applied to the processes of specialist re-certification operated, in order to ensure value for money.

This gives Medical Royal Colleges the opportunity to provide the assessment process. For example, our College could develop assessment tools to be made available to doctors, who would then return assessments to the College. These
would be scored and we would be able to give feedback on performance, not only absolute levels but also compared to a cohort of similar practitioners in the same way as we currently do for trainees multi-source feedback. We could develop a similar process for all forms of assessment throughout the training and career of paediatricians. Information that is derived can be used both formative within appraisal as part of CPD as well as the summatively which will contribute towards revalidation.

Membership or Fellowship of a relevant Medical Royal College is not mandatory for specialists at present and this recommendation suggests that it should be.

The responsibilities that this recommendation confers onto Royal Colleges in terms of establishing Members’ fitness to practice in their specialty has implications for risk management, and would need careful consideration in implementation. We would question the phrase ‘in order to ensure value for money’ in the final sentence of the recommendation.

Recommendation 32:

Where doctors fail to satisfy the requirements of either element of revalidation, they should spend a period in supervised practice or out of practice, prior to assessment, in order that a tailored plan of remediation and rehabilitation may be put in place.

This recommendation will require a detailed, clear process to be developed by the GMC. Is there evidence of the efficacy of such programmes?

It is unclear how the costs would be met of maintaining a doctor out of practice or in supervised practice. Who would be responsible for the organisation of a rehabilitation programme and who would fund it?

Recommendation 33:

A wide and inclusive clinical audit advisory group should be formed nationally to drive the further development of local and national clinical audit programmes, yielding publicly available information to accelerate improvement in practice and service delivery.

This is a commendable idea in principle. However, devising appropriate clinical audit programmes that are applicable across institutions and that genuinely reflect on the quality of care offered is not without difficulty. Even where achievable it will very often reflect quality of team work and may be affected by restrictions on resources. Therefore the extent to which this will reflect an individual’s fitness to practice is limited.

Recommendation 34:

The NHS should support the routine monitoring of significant events in general practice through the contracts of general practitioners, further developing and piloting a national system for death monitoring as part of a wider clinical quality assurance framework in general practice. In addition, the Royal College of General Practitioners should be asked to work with the NHS Business Services Authority to assess the suitability of the information held on the
prescribing habits of individual practitioners in primary care for use in assuring the performance of practitioners. Further work should also be undertaken with the College to examine the wider role of practice profiling and the use of other routinely available data in the assurance and improvement of the quality of services delivered in primary care.

No comment.

Recommendation 35:

In their role as commissioners of services, the responsibility for assuring that lessons are learned from specific medical errors and complaints should be made statutory for primary care trusts.

No comment.

Recommendation 36:

Further attention should be paid to ensuring the formal and personal accountability of individual general practitioners to their primary care trust, through use of standard contracts and other mechanisms. In particular, primary care trusts should be guaranteed unfettered access to all patient records.

No comment.

Recommendation 37:

The opportunity to use financial incentives to promote safe practice should be examined by an expert group. In particular, the relationship between the quality of clinical governance processes within NHS organisations and the premiums paid by them to the NHS litigation authority, and the relationship between individual practitioners and the premiums paid by them to medical insurers, should be explored.

This suggests using financial incentives to promote safe practice. This is unethical - if you choose not to accept the incentive, can you practice badly?

C. Recommendations 38 – 44: Better information for the public, employers and professional bodies

Recommendation 38:

The Medical Register should be the key national list of doctors entitled to practice in the United Kingdom and should contain tiers of information (some publicly available, others available with restricted access) about each doctor and their standard of practice. The new Medical Register should be a continuously updated electronic document that would over time subsume a number of other lists and registers currently in place, including primary care performers lists, which should cease to be a statutory requirement.

No comment.
Recommendation 39

The Medical Register held by the General Medical Council should contain two tiers of information: that which is freely available to the public and that which is secure, with access limited to the individual registrant, General Medical Council affiliates and approved employers and contracting bodies. The following information should be freely available: registration status; date of expiry of licence to practice; specialist certification or inclusion on the GP register and date of expiry of the same; any interim restrictions on practice in force; and any substantive restrictions in force. The secure tier of information should include full demographic information (including electronic contact details), the fact that an investigation by the General Medical Council is in progress if that is the case, and any ‘recorded concerns’.

No comment.

Recommendation 40:

Each doctor on the Medical Register should be given a unique and permanent identifier. Those doctors who wish to gain full registration without having previously held student and provisional registration should be required to submit written references from all their previous medical regulators. They may also be required to attend for interview.

No comment.

Recommendation 41:

Systems should be developed such that when a patient switches registered doctor without changing their address, that patient is offered a confidential interview with a member of staff from the primary care trust, at a place of their choosing.

No comment.

Recommendation 42:

The primary role of the members of the General Medical Council should be the appropriate corporate governance of the organisation. This role is one of accountability for the quality of services delivered by the organisation in respect of: registration functions; the maintenance of accurate, up-to-date information; the investigation and prosecution of fitness to practice cases; the operation of the devolved system of licensed affiliates; the oversight of revalidation, and the effectiveness of working arrangements with partner organisations.

No comment.

Recommendation 43:

The composition of the General Medical Council should be changed to reflect its new responsibilities. It should become more ‘board-like’. Its members should be independently appointed by the Public Appointments Commission, and its President elected from amongst those members.
We would point out that it is an apparent conflict of interest that doctors vote for the members of the regulatory body that potentially judges them. We would propose that all the medical members should be appointed from nominations made by Royal Colleges. There should be an equal number of medical and lay members. The President should always be a lay member.

**Recommendation 44:**

The General Medical Council should be accountable to Parliament, to which it should be required to present a detailed annual report.

No comment.

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