Is the General Medical Council in need of revalidation?

ABSTRACT

The General Medical Council was originally set up to 'protect, promote and maintain the health and safety of the public'. In 2012, the Privy Council instructed the General Medical Council to set up and run a licensing and revalidation system for all practicing doctors in the UK, to protect patients from actions of medical staff. Despite this mandate, the General Medical Council has been a bystander in a series of regulatory failures. Without these episodes having been highlighted by family members, public investigations would not have been carried out. The maintenance of medical performance is delegated to NHS employers, which could cause conflicts of interests when employers have to investigate doctors as part of a team.

The other responsibility of the General Medical Council is to monitor teaching standards and curricula of medical schools in the UK, which it does by eliciting feedback from students and trainees. The General Medical Council has not responded to 'new ways of working' (especially in England) involving non-medical staff undertaking tasks previously carried out by doctors. Furthermore, the General Medical Council has not updated its description of the role of the future doctor in light of increasing use of technology, use or non-use of which could both be considered to be evidence of poor practice.

The General Medical Council was created as part of the UK Medical Act in 1858. This described its main objective as 'exercising its functions to protect, promote and maintain the health and safety of the public', which it carries out by maintaining a list of registered practitioners. Since 2012, the General Medical Council has also been instructed by the Privy Council to set up and run a licensing and revalidation system for all practicing doctors in the UK.

Despite the wide-ranging powers of investigation and prosecution available to the General Medical Council to act in effect as the 'police force of doctors', there have been a series of regulatory failures, with the General Medical Council having to apply safeguards retrospectively following outcries by the family members of patients who died.

The original incidents involved children treated by cardiothoracic surgeons in Bristol (Kennedy, 2001) and consultant pathologists at Alder Hey (Redfern et al, 2001). More recently similar incidents involving medical consultants have been reported in Mid Staffordshire (KPMG, 2009) and a non-consultant senior in Gosport involving incapacitious elderly patients (often with dementia or delirium) who, without due consultation, were placed by doctors on end of life pathways including use of intravenous opiates to precipitate death (Gosport Independent Panel, 2018).

It appears that the General Medical Council is less proactive and/or effective in investigating and prosecuting teams than individuals as illustrated in Bristol and Mid-Staffordshire. This is especially true when neither local management nor doctors have expressed concerns, which has lead to accusations of collusion, because of potential financial benefits. Cases have only been brought to light by medical and nursing whistleblowers, who consequently have had to move elsewhere to continue their careers. At the same time, doctors' respect for the General Medical Council has deteriorated (Wickware, 2018), because of a perception that the General Medical Council can be unfairly draconian in pursuit of junior doctors, especially doctors of colour, as exemplified by their treatment of Dr Hadiza Bawa-Garba.

There has been no attempt to review the actual curricula in medical schools; for example to remedy the lack of education on nutrition, sleep hygiene and exercise in maintaining health and wellbeing, and the lack of understanding of the consequences of artificial intelligence in medical practice in the 21st century. Medical students will need to understand the role of these developments in their future practice, including the ethical and moral repercussions.

The other key role allocated to the General Medical Council is to inspect and validate the curricula of all UK medical schools, by assessing teaching resources and collating medical student and foundation trainee feedback of their educational experience. Findings of high rates of depression (~ 30%) among medical students (Rotenstein et al, 2016) and junior doctors (Mata et al, 2015) compelled the General Medical Council (2015) to provide guidance for NHS trust employers about detecting mental ill health among junior doctors.

Emerging themes

There appears to be increasing diversion between the devolved nations in applying 'new ways of working' for doctors. This suggests that the General Medical Council may need to be devolved itself to accommodate this movement.

In particular, NHS trusts in England are introducing other practitioners such as non-medical prescribers,

Dr Prasanna de Silva, Consultant Old Age Psychiatrist, Department of Psychiatry, Northumberland, Tyne and Wear Foundation Trust, Monkwearmouth Hospital, Sunderland SR5 1NB and Honorary Senior Lecturer, Sunderland University (Prasanna.desilva@ntw.nhs.uk)

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physician assistants, paramedics and nurse specialists to take on practical tasks previously performed by doctors, such as insertion of chest drains, lumbar punctures, intubation and gastroscopy. These practitioners are being intensively trained and supervised, undertaking these procedures at a much higher frequency than doctors in training, with the result that junior doctors have to compete for opportunities to gain experience. This could extend the duration of training and become a threat to their future career prospects. There is no clarity from the General Medical Council as to how these non-medical practitioners should be supervised, for example if responsibility for their actions rests with the doctor who is supervising them or with the employing NHS trust (the 'third party' in the doctor–patient relationship).

Furthermore, over the next 5 years, NHS trusts will be incorporating advances in artificial intelligence, including diagnostic aids and treatment algorithms. The General Medical Council has not formally commented on the application of artificial intelligence. If an artificial intelligence-derived outcome becomes the 'gold standard' for any particular decision it will significantly restrict the independence of the doctor, and will also restrict the choices offered to patients and their carers.

What the General Medical Council has done already

The General Medical Council's main response to continuing regulatory failures has been to separate their investigatory and prosecuting roles from their adjudicating role by setting up the Medical Practitioner Tribunal Service. However, crucially, the General Medical Council retained its right to appeal decisions made by the Medical Practitioner Tribunal Service in the High Court (as it did with Dr Bawa-Garba). It is argued that Dr Bawa-Garba would not have been found guilty in the equivalent high court in Scotland, making her prosecution something of a 'postcode lottery'.

The General Medical Council has made efforts to train Medical Practitioner Tribunal Service members in equality and diversity and to lessen pressure on the Medical Practitioner Tribunal Service by looking at NHS trusts who refer fewer doctors to find out how they managed to reduce referrals to General Medical Council tribunals. However, there has been no attempt to look into the phenomenon of senior doctors acting collectively in an inappropriate way, thus risking patient safety.

Following the Bawa-Garba appeal in the High Court (which resulted in her reinstatement onto the medical register), the General Medical Council chief executive arranged for an independent review of General Medical Council prosecutory practice as a result of the widespread disquiet among the profession as a whole. This has recommended the following (Hamilton, 2019):

1. Doctors being investigated after the death of a patient should expect official investigations to take into account their working environments and pressures
2. There should be a consistent approach to investigations by all health-care providers
3. The chief coroner should be consulted before any gross negligence manslaughter case is escalated to the police and Crown Prosecution Service
4. Improved quality assurance of medical expert evidence is needed in cases of gross negligence manslaughter and culpable homicide
5. That the General Medical Council urgently repairs its relationship with the profession.

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The General Medical Council has considered the benefits and drawbacks of closer working with the Care Quality Commission but this is not at present mandatory. Currently, Care Quality Commission inspections do not include General Medical Council representation, and the General Medical Council does not routinely provide the Care Quality Commission with information about problem doctors who are working (or have worked) in NHS units awaiting inspection. This exchange of intelligence could lead to detection of systemic and cultural issues in a particular workplace. Although the bureaucratic complexities would be challenging, they would not be insurmountable.

Lessons to be learnt from police services

It is arguable whether or not the General Medical Council can be compared to the police services, although there is a shared duty to prevent harm to the general public. Nevertheless, in a spirit of learning from other organizations, the General Medical Council could look at how the more effective police services have worked to reverse harm to their catchment populations. Also, examination of poorly performing police services could provide salutary models in terms of the kinds of issues identified (Her Majesty's Inspectorate of Constabulary, 2009).

Most police services have listened to 'officers on the beat' about the need to focus on preventing clusters of crime as much as apprehending suspects following criminal activity (SAS, 2013), especially with availability of improved surveillance technology. The basis of contemporary community policing therefore is to provide consistent presence on the ground, with the trust generated leading to better intelligence. Police services also have a responsibility to share intelligence with other agencies involved in safeguarding, for example on frail elderly and other vulnerable people, such as those with learning disabilities.

Police accept that it is easy to catch minor offenders but that they face major difficulty breaking up higher level criminal rings, because of their legal back up, power to

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deal with whistleblowers and their talent for covering up for each other. They believe that cooperation with other agencies and the general public can produce significant success in dealing with crime syndicates. They accept that preventing murderous acts of individuals is nigh impossible (like Harold Shipman), but continued vigilance by the general population (doctors, nurses and students in the case of the General Medical Council) has the potential to prevent repetition. Overall, the police accept that public trust in terms of easy access and effective responses is key to continued supply of intelligence (Jackson and Bradford, 2010). Not all is perfect in the police – there are allegations about ‘institutional racism’ linked to poor leadership (Green et al, 2000) – but this does not mean that lessons cannot be drawn from their experience.

Potential ways forward

Mandated joint working between the General Medical Council and Care Quality Commission

Joint working between the General Medical Council and Care Quality Commission would mean that the General Medical Council’s responsibility to investigate specific problem doctors and senior medical teams could be linked with the relevant Care Quality Commission team who have inspected (or are intending to inspect) hospital departments or GP practices in which the doctor works (or used to work). This would provide the General Medical Council with the necessary context to investigate the liability of a faulty doctor, including understanding resources such as medical and non-medical staffing, supervision and physical infrastructure (as exemplified by the case of Dr Bawa-Garba).

The Care Quality Commission also affords robust whistleblowing protection, which may reassure students and non-medical staff that they can highlight concerns that they have about senior staff. Sharing intelligence would also avail the General Medical Council of ‘soft’ intelligence on medical performance which is often picked up by the Care Quality Commission, for example misuse of analgesia or psychotropics.

Splitting the General Medical Council to the devolved nations

Splitting the General Medical Council and/or Medical Practitioner Tribunal Service functions to the devolved nations to be linked with the relevant health inspectorate (such as the Care Quality Commission in England) might reduce overhead costs and share lessons learnt by the two organizations. Doctors inevitably work as multidisciplinary teams with non-medical colleagues, and issues pertaining to a single doctor (or a team of consultants) impact on, and are influenced by, others, including management. The combined infrastructure at investigatory level, and at the level of the decision about whether formal proceedings are required, would allow both the General Medical Council and Care Quality Commission to work towards preventing poor performance by doctors, nurses and managers within teams.

Reducing referrals to the General Medical Council

Understandably, the General Medical Council is concerned about the high rate of referrals for assessment and remediation, largely as a result of the expense involved and pressures on Medical Practitioner Tribunal Service teams. It is aware that the better performing trusts are less likely to refer. Also there is circumstantial evidence that medical managers who have been reported to the General Medical Council themselves are less likely to refer a doctor to the General Medical Council.

Mental health trusts have a valuable role in advising acute trusts about how to manage problem doctors with mental health, relationship or substance abuse issues, and preventing problems occurring so that fewer doctors face General Medical Council procedures. Furthermore, there is a case to be made for neighbouring trusts to assist each other in initially investigating and managing problem doctors, but this would depend on the General Medical Council backing up the judgements and decisions made.

Setting up transparent mortality tables

Setting up transparent UK-wide mortality tables for each hospital, broken down to individual clinical departments, was one of the core recommendations of Dame Janet Smith’s Shipman report (Smith, 2003), and of Sir Bruce Keogh’s report on failing hospitals (Keogh, 2013). This remains difficult to achieve as departmental rates are not available, and there is variation in how hospital deaths (including post-discharge deaths) are analysed between England and Scotland. These are not insurmountable problems, and the effective introduction of the medical examiner system would be a good start (Elwyn, 2006).

The resultant mortality tables for each department would show evidence of groups of consultants who were failing in terms of patient safety. Currently, this function is carried out partially by Dr Foster’s standardised mortality ratio figures (Little, 2002). Perhaps the General Medical Council should take ownership of this process, leading to prompt investigation if worrying clusters appear to be forming. As above, subsequent collaboration with the Care Quality Commission in investigating problem clusters would make sense, as the Care Quality Commission would have relevant soft intelligence from their site visits.

Changing the culture towards a ‘learning organization’

To be fair to the General Medical Council, this is already starting to take place, considering the Chief Executive’s

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response to the Hamilton report on Bawa-Garba. However, widespread organizational change in the culture within the General Medical Council could be difficult to achieve. It will have to include a shift away from a policy of confrontation and enforcement to one of humility and learning lessons within the organization.

There will be a need to train General Medical Council investigators and lawyers, as well as Medical Practitioner Tribunal Service members, about how to avoid biases of groupthink, escalation of commitment, confirmation bias and affective bias, all common problems in any group of professionals (de Silva, 2009). The General Medical Council needs to have input from doctors who have been through the General Medical Council investigatory process. These doctors can provide insights about context, and explain what the individual doctor under investigation could be going through. This is very important because in the typical Medical Practitioner Tribunal Service case support from the employer is usually absent.

Conclusions

In order to survive as an organization, the General Medical Council needs to refocus on its primary purpose: protecting patients. It needs to collaborate with other organizations – in a similar way that the police services have – and increase preventive work, thus avoiding clusters of excess mortality, in order to maintain trust both of the general public and doctors. One obvious suggestion is that a statutory working relationship should be established with the Care Quality Commission (or the equivalent in the devolved nations).

The more difficult aspect is culture change within the General Medical Council to transform itself into a genuine learning organization – especially reflecting on actions which, in retrospect, could have been mistakes. Input from doctors who have been investigated and thereafter continued in clinical and managerial careers will be a very useful way to facilitate the necessary change in perspective that is required.

Overall, the General Medical Council needs to build a trusting relationship with students and doctors at the coalface and with the overall health community. Keogh noted that younger doctors (and presumably students) may perhaps be more reflective and willing to talk about what they observe, and the General Medical Council and Care Quality Commission should take advantage of this. **BJHM**

Conflict of interest: Dr P de Silva worked for 2 years up to October 2017 as a specialist advisor for the Care Quality Commission, inspecting old age mental health facilities of 23 mental health trusts. The opinions expressed in this article are those of the author, not of the Care Quality Commission.

KEY POINTS

- The General Medical Council was originally set up to 'protect, promote and maintain the health and safety of the public'.
- Despite this, the General Medical Council has been a bystander in a series of regulatory failures typically involving groups of consultants, with excess deaths mainly involving incapacitated elderly patients.
- The General Medical Council has no preventative responsibilities in terms of maintaining medical performance – these are delegated to NHS employers.
- The General Medical Council is also responsible for monitoring teaching standards and curricula of medical schools in the UK.
- The General Medical Council has not updated its description of the role of the future doctor, in light of increasing use of technology.

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