MORE THAN DEFENCE

Consultation Response

The General Medical Council (GMC): *Developing the UK Medical Register*

September 2016

The Medical Protection Society (MPS) response to the GMC's consultation on proposed changes to the List of Registered Medical Practitioners (LRMP) in the UK

General Comments

MPS is pleased to have this opportunity to respond to the GMC's proposals for significant reform of the medical register – the LRMP.

The LRMP's core purpose is to document - and make accessible – the census of those registered and licensed to practice medicine across the UK. The GMC's ambition, stated in this consultation, is to make the LRMP "the most advanced, transparent register in the world."[1] MPS has carefully studied the GMC's vision for a new register, and the proposals to bring it about. There are a number of concerns relating to both, and we outline those concerns in response to the specific consultation questions below.

Fundamentally, MPS is of the view that these proposals amount to a significant departure from the scope, purpose and intention of the LRMP, as outlined in *S.2* of the *Medical Act 1983*.

The proposed expansion of the register would leave a registrant's record prone to error and misinterpretation; see the register become a more intrusive instrument; place a greater onus and requirement on the registrant to maintain their entry - to cite just a few issues associated with the GMC's proposals.

The GMC should not proceed with its current plans to reform the LRMP. MPS urges the GMC to reconsider its vision for what the register should be.

In short, as is currently proposed, MPS does not believe the new LRMP would be able to command the confidence of doctors about the information it holds on them – which goes against one of the GMC's core ambitions. We outline our specific concerns below.

[1] The GMC, Developing the UK Medical Register (2016): A public consultation. Pg.1

Consultation Questions

1. Do you agree with the purpose of the medical register described in this section of the consultation?

MPS disagrees with some of the assertions that the GMC has made in relation to the purpose of the medical register.

The purpose of the medical register is clearly defined in *S.2* of the *Medical Act 1983*. The register should contain the information necessary to validate the doctor and their qualification – an essential and indispensable function for employers, and crucially, for patients.

The GMC's assertion, that the register must evolve to satisfy a greater demand for information about health professionals, and remain relevant, is incorrect. The register remains relevant today because the information contained within it is robust and up-to-date. Namely, those individuals registered with a license to practice and whether they are on the specialist or GP register. The GMC's proposals to add substantially more information to the register is a risk to that robustness, and to its status as a fully up-to-date source of information.

It is not for the GMC to seek to emulate or compete with websites such as *NHS Choices* and *IwantGreatCare.org* – both of which feature as a case study in the proposals. These more local based websites have the potential to not always provide the most up-to-date information; a scenario which could take on a much greater significance for both patients and the profession when such information is housed on a statutory regulatory register, namely the LRMP.

The GMC's ambition should be for information held on the register to be fully up-to-date, accurate, and dependable. This is the register's core purpose and current function, and should remain so.

2. Do you think that the register should serve any additional purpose? If so, what should that be?

No, MPS does not believe that the register should serve any additional purpose.

The GMC is firstly and exclusively a regulator. It is not for the GMC to act as a quasi-advertising platform, or for it to replicate and provide information that can be housed elsewhere. There are many ways for a doctor to publicise material about themselves should they wish to do so. The LRMP is not the place for this.

3. Do you agree that these are the right principles to guide the inclusion of additional information on the register?

The principles the GMC lists on page eight of the consultation appear sound, and MPS agrees that these are a good guide. However, we would question whether the detail and implications of the GMC's proposals for change, and including additional information on the register, meets these same principles.

4. Are there other principals that should be included? If so, what are they?

The GMC should also state clearly, that the need to ensure the safety and privacy of a doctor and their family is an important principle for it to take forward.

MPS is firmly of the view that the GMC owes its registrants a duty of care, and this should be reflected in the principles underpinning the information it seeks to hold on the register.

5. Do you agree that we should develop a tiered approach to information on the register along the lines described? Why?

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6. Do you agree that making provision for some categories of registration information voluntary would help mitigate some of the possible disadvantages of our proposed two-tier model?

MPS has considerable concerns about the proposals for a tiered approach to the register – with Tier 1 being compulsory information, and Tier 2, voluntary.

It is foreseeable that it could rapidly become a *perceived* expectation for the doctor to include the voluntary Tier 2 information as standard practice. Indeed, as the GMC states at page four of the consultation – it is its view that information on the register must be useful and meet the needs and demands of those wishing to use it. Therefore, it is quite probable that as more registrants add a photograph of themselves (voluntary Tier 2 information) to their entry on the register, others will feel obliged to do so in order to satisfy the GMC's ambition to continuously meet growing patient demand for more information. By implication, MPS would be concerned that Tier 2 information could quickly become compulsory information rather than voluntary, thus making the tiered approach redundant.

Also, it is misleading for the GMC to state that it would be the responsibility of the doctor to keep information on the register up-to-date. That would also be the GMC's responsibility – regardless of whether the information was Tier 1 or Tier 2. The GMC is a data controller, and any data it holds and publishes on the register must be checked against its responsibilities under the *Data Protection Act 1998 [DPA]*. The GMC would have a responsibility to ensure that the information it holds on the online register is relevant and not excessive; accurate and up-to-date; only retained for as long as necessary. Namely, principles three, four and five respectively of DPA.

Fundamentally, the compulsory information contained within the proposed Tier 1 replicates the information already contained on a registrant's entry on the medical register. The GMC should maintain this approach, and not move towards including additional, voluntary information, as included in the proposed Tier 2.

7. Are there particular groups who would be helped or disadvantaged by our approach to providing more information on the register? If so, which groups and why?

MPS has no comment to make in respect of this question.

8. Are there other disadvantages associated with the two tier model which have not considered here? If so, how might they be mitigated?

Other than those already detailed in response to questions five and six of this consultation, MPS has no further comment to make in respect of this question.

9. Which of the following categories of information do you think would be useful to include on the register? Please indicate whether this should be Tier 1 information, Tier 2 or if neither please leave blank.

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10. If there are categories of information listed above that we shouldn't attempt to collect, please explain why.

MPS holds that the information listed under Tier 1 – namely, the information already held on the medical register – should remain the only information contained on the LRMP. We highlight specific concerns we have with three of the proposed additions below.

Employment history

This should be neither Tier 1 nor Tier 2. This information would be a highly cumbersome entry on the register, and thus contradict the GMC's ambition to make information held on the LRMP 'accessible'. MPS is also of the view that such a detailed history is not relevant to the purpose of the medical register.

Languages spoken

This should be neither Tier 1 nor Tier 2. A consistent concern MPS has with proposals for including all this additional information is the additional risk it would present to the doctor – particularly in respect of regulatory action.

'Languages spoken' is a notable example. For instance, if a doctor was to voluntarily include on their entry on the register that they speak French and Japanese, the question is raised as to what level of proficiency the GMC expects this to be. This is an important point, as the GMC has stated that it is the doctor's responsibility to ensure the information they include on their entry on the register is accurate, as information about languages spoken would not be validated in the same way that current information held on the register is. So a doctor could, in good faith, include French and Japanese as their spoken languages, even though their competency is only 'conversational'. A member of the public then searches the register looking for a specialist in a given filed of medical practice, who can also speak *fluent* Japanese. Upon visiting the doctor, with the patient expecting to be able to have a fluent conversation in their first language (Japanese), they find that is not possible and so feel mislead. Were that to lead to a complaint to the GMC, the question is raised as to whether it would lead to a charge of dishonesty against the doctor.

While recognising that such a scenario represents the extreme end of the spectrum, the question still remains about how competency would be judged by the GMC – as the lines in language competency between 'Intermediate' and 'Advanced' are incredibly subjective. The inclusion of 'languages spoken' on a doctor's entry on the medical register is a pertinent example of how the GMC's ambition to expand the scope of the LRMP could unnecessary complicate matters, and lead to it losing the status of a thoroughly robust and up-to-date reference source about the doctor.

Registrant's photo

This should be neither Tier 1 nor Tier 2. MPS has already outlined our concerns regarding including a registrants photo on the register, in response to questions five and six of this consultation.

It is not uncommon for doctors to attract media attention when they are investigated by the GMC. The adverse impact on both the doctor and their family can be significant. MPS provides support to

members who experience such attention, and so is very much aware of the scale of that impact. Any situation whereby including a registrant's photo on the register became compulsory, or even expected, would be highly concerning. The photo would be readily accessible to the press, and the GMC should have regard to the registrant's privacy.

We noted with interest the GMC's case study at page six of the consultation, where it states that the Medical Council of New Zealand provides more information on its register than the GMC does on the LRMP. On the question of privacy, the GMC may wish to look at the Medical Council of New Zealand's approach to the way it investigates doctors over their fitness to practise. In contrast to the GMC, it typically does not publically name a doctor it is investigating, as it considers to do so would be overstepping its statutory function of ensuring the health and safety of the public. If the GMC is seeking to expand the LRMP, and borrow practice from other medical regulators around the world, it should first look to assess how the additional information it proposes including sits alongside its current regulatory practice.

11. What other categories of information would you find useful to include on the register?

None. MPS is of the view that the level of information currently held on the LRMP is sufficient to fulfil the GMC's purpose of protecting patients through validating doctors' fitness to practise medicine in the UK, as well as their qualifications and where appropriate, speciality.

12. Do you agree it is sufficient for Tier 2 information to be subject to verification through sample audit, provided the status of the information is made clear to those consulting the register?

MPS does not agree with including Tier 2 information on the LRMP. Tier 1 information should remain as is.

13. If you've used the online register, do you have any thoughts on how we can improve it and make it more user friendly.

MPS staff regularly use the online register in the course of their work, and the feedback is that it is both adequate and appropriately accessible. It is also noted from the consultation document that in 2015, there were nearly 7 million searches of the register.[2] Such a large number of searches, we believe, indicates a widely held experience of good accessibility.

[2] The GMC, Developing the UK Medical Register (2016): A public consultation. Pg.6

About MPS

The Medical Protection Society Limited ("MPS") is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum of Articles of Association.

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

Thomas Reynolds
Policy and Public Affairs Manager

Email: thomas.reynolds@medicalprotection.org

The Medical Protection Society Limited
33 Cavendish Square
London W1G 0PS
United Kingdom

Tel: +44 (0)20 7399 1300
Fax: +44 (0)20 7399 1301

info@medicalprotection.org
medicalprotection.org