CHAPTER EIGHTEEN

The General Medical Council Conduct Procedures: Initial Stages Conducted by the Administrative Staff

Introduction

18.1 I have already explained that the General Medical Council's (GMC's) old conduct procedures dealt with doctors who had been convicted of criminal offences and those who were alleged to have been guilty of serious professional misconduct (SPM). All complaints about a doctor's conduct and all information that a doctor had been convicted of a criminal offence received by the GMC were considered first by members of the administrative staff. I have already explained in Chapter 15 that complaints made to the GMC underwent a series of filtering processes. As a result of those filtering processes, the vast majority of cases were closed without reaching the stage of a public hearing by the Professional Conduct Committee (PCC).

18.2 The first of those filtering processes was conducted by the administrative staff, who applied various set criteria in order to determine whether a case should be closed at that initial stage or whether it should advance into the fitness to practise (FTP) procedures. In 2003, members of the administrative staff were responsible for closing 65% of the 3821 complaints about doctors' conduct or performance which were received by the GMC in that year. In view of the fact that so many cases were closed at this early stage, as a result of decisions taken by the administrative staff, it was clearly important for the Inquiry to examine the processes undertaken by the staff and the criteria on which their decisions were based.

18.3 In this Chapter, I shall describe briefly the processes undertaken by the administrative staff on receipt of a complaint or report about a doctor. I shall consider the circumstances in which members of staff were in the past permitted to close a case and the criteria which they were required to apply. I shall also look at the procedure for dealing with information about convictions. I shall examine the extent to which the decisions made by members of staff were subjected to audit.

18.4 I shall then proceed to consider some specific issues arising from the processes undertaken by members of staff. In particular, I shall be considering the policy of the GMC, which was current for many years, of instructing its staff to advise complainants that they should pursue their concerns through local complaints procedures. I shall also consider whether there was any, or any adequate, follow-up of such cases by the GMC. I shall go on to consider whether complaints and reports to the GMC have in the past been properly investigated. I shall consider whether there has in the past been an adequate exchange of information between the GMC and the employers and primary care organisations (PCOs) of doctors in respect of whom complaints have been made. Finally, I shall examine some problems which have arisen in connection with decisions to close cases, by reference to some individual cases which have been dealt with by the staff. To enable me to do this, the Inquiry obtained and examined a small number of cases which had recently been closed by members of the administrative staff. The intention behind examining these

cases was to gain some insight into how the processes described by the GMC worked in practice.

Witnesses

18.5 The Inquiry heard oral evidence from Mr Alan Howes (who was employed by the GMC between 1977 and 2002 and was Head of the Conduct Section from 1987 to 1994), from Mr Antony Townsend (Deputy Head, later Head, of the Conduct Section from 1994 to 1998), Mr Finlay Scott (Chief Executive of the GMC since 1994) and Mr Neil Marshall (Head of the Screening Section since March 2002). Professor Sir Graeme Catto (current President of the GMC), Dr Krishna Korlipara (a member of the GMC since 1984 and a medical screener from 1998 until 2004) and Professor Isobel Allen (Emeritus Professor of Health and Social Policy, University of Westminster Policy Studies Institute (PSI)) also gave relevant evidence.

The Screening Section

18.6 Information about convictions, together with all complaints and communications about doctors, were dealt with initially by the Screening Section. The exception was when the information or complaint clearly related to issues affecting the health of a doctor. Those cases were directed straight to the Health Section. The Inquiry was told that, as at December 2003, the staff of the Screening Section consisted of three casework managers, 29 caseworkers, 11 casework assistants and a secretary. A caseworker had the primary day-to-day responsibility for each case, with guidance from casework managers and administrative support from casework assistants.

Sources of Reports about Doctors

Convictions

18.7 The GMC receives information about doctors who have been convicted of criminal offences, or who are the subject of ongoing criminal investigations or proceedings, from a number of sources. It employs a press cuttings agency to alert it to criminal cases involving doctors that are going through the courts or have resulted in convictions. Home Office Circulars require the police to report certain types of convictions to the GMC. In addition, a doctor's involvement in criminal investigations or proceedings may be reported to the GMC by the Home Office Drugs Branch, by the doctor's employers or PCO (in England, a primary care trust (PCT)), by a member of the public or by the doctor him/herself. These systems are not foolproof and, sometimes, there is a long delay between the date of a conviction and the time when the GMC is notified of it. Some convictions have been missed altogether.

18.8 In the past, there was no professional obligation on a doctor to inform the GMC of the fact that s/he had been convicted of a criminal offence or of the fact that s/he was the subject of a criminal investigation or of criminal proceedings. As I have explained in Chapter 5, general practitioners (GPs) have been required since December 2001 to declare such

matters to the PCO on whose list they are included within seven days of the commencement of criminal investigations or proceedings, or of a criminal conviction. They have also been required to disclose, *inter alia*, the fact that they have accepted a police caution or are subject to an investigation into their conduct by any licensing, regulatory or other body anywhere in the world. However, there has been no formal mechanism whereby PCTs would automatically inform the GMC when they received such a declaration. My understanding is that PCTs would do so if they thought it appropriate.

18.9 In September 2004, as a result of discussions which took place during the course of Mr Scott's evidence to the Inquiry, the GMC decided that doctors should be placed under a professional duty to disclose to the GMC information about impending and past criminal and regulatory proceedings. The precise terms of the duty have not yet been finally decided but it is likely to include an obligation to disclose information about convictions and criminal charges brought against doctors (save for those in relation to certain minor motoring offences), about police cautions accepted and about proceedings brought against them by other regulatory bodies in the UK or elsewhere. The new duty is to be included in the next edition of 'Good Medical Practice'. Failure to comply with the duty may result in disciplinary proceedings. This change is welcome and brings the medical profession in line with other professions, including barristers.

18.10 Until 1991, the term **'convicted ... of a criminal offence'** excluded a finding of guilt in respect of which a doctor was placed on probation or was discharged conditionally or absolutely. After 1991, the exclusion applied only to findings of guilt where a conditional or absolute discharge was imposed. Such findings of guilt have, however, frequently been reported to the GMC by the police. It has then been open to the GMC, if it chose, to proceed with the case as if it were an allegation of SPM. On occasion, the fact that a doctor has accepted a police caution might also be reported to the GMC. If this occurred, the GMC might then elect to treat the report as an allegation of SPM. The new FTP procedures specifically provide that a police caution should be treated in the same way as a conviction. I shall recommend also that offences which have been dealt with by means of a conditional discharge should be treated in the same way as a conviction.

Complaints

18.11 The GMC also receives complaints about the conduct of doctors from many sources, mainly from NHS trusts, from doctors' employers, from patients and patients' families and from other healthcare professionals. Some of these complaints are serious and it has been clear from the start that, if proved, they would amount to SPM under the old conduct procedures. Others are so trivial that, even taken at their highest, they could never warrant disciplinary action by the GMC or, indeed, by any other body. Many fall somewhere in between these extremes. Some complaints do not relate to a doctor's medical practice at all, but to some personal matter involving the doctor.

Other Communications about Doctors

18.12 The GMC also receives some communications about doctors that cannot properly be termed 'complaints'. These may be requests for information or questions about medical

ethics. Some of the communications do not relate to doctors at all. Like any other public body, the GMC also receives some communications that are irrational or incoherent. All these communications must be considered by the staff and a decision taken as to whether they require positive action by the GMC. If the staff judge that they do not require any such action, they are 'closed' at this stage.

The Initial Processing of Conduct Cases under the 'Old' Procedures

18.13 The old conduct procedures were governed by the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (the 1988 Professional Conduct Rules). In December 2003, the relevant instructions for staff were contained in the April 2003 edition of the FTP Casework Manual. Subsequently, new instructions were issued and were contained in the FTP Investigation Manual, the first version of which came into effect in May 2004. The FTP Investigation Manual included changes to the procedures for dealing with complaints which had been introduced after the Inquiry's hearings. Most of those changes related to new arrangements for the exchange of information between the GMC and the employers and PCOs of doctors in respect of whom complaints had been made to the GMC. I shall describe those new arrangements, which were introduced as a result of concerns expressed by the Inquiry, later in this Chapter.

18.14 In the course of the decision-making process, members of staff used specially designed standard forms to guide and record their decisions.

The Practice in December 2003

The First Steps

18.15 I shall deal first with the procedure for handling complaints involving allegations of SPM and other communications about doctors (I shall refer to them collectively as 'complaints'), as described by the witnesses in December 2003. The procedure for handling information about convictions was different and I shall describe it later in this Chapter.

18.16 When a complaint was first received, some preliminary information was entered by hand onto a case direction form (CDF) by a casework assistant. The CDF was designed to provide a record of the procedural steps taken, of the preliminary decisions made and of instructions issued about the future conduct of the case. Details of the case were entered onto the GMC's database, which was updated as the case progressed.

18.17 A number of standard procedures would then be carried out. If the complaint related to a named doctor, attempts would be made to confirm his/her identity by reference to the GMC's medical register. This was not always possible, for reasons that I shall explain later in this Chapter. If the doctor could be identified, a search of the GMC's database would be made in order to ascertain whether s/he had previously been reported to the GMC. The results of the search, together with the nature and outcome of any previous complaints found, would be recorded on the CDF. A search was also made to see whether the complainant had made previous complaints to the GMC. The case would then undergo an initial 'triage' by a casework manager.

Triage

18.18 The triage was an initial assessment, undertaken by casework managers in order to determine which cases could be closed immediately and which should be taken forward. The casework manager might decide that a communication was not a complaint at all but was an item of general correspondence. If so, it would be filtered out at the triage stage. The casework manager might be unable to take a final decision about the disposal of the complaint. He or she might require further information before doing so, in which case s/he would pass the case to a caseworker and give any necessary instructions and advice on what was to be done. The casework manager would identify cases that needed to be dealt with urgently for some reason and would give appropriate instructions to the designated caseworker. Where the casework manager felt that there was sufficient information on which to base a decision, s/he would proceed to decide whether the case should be referred to a medical screener.

18.19 There were two other matters that the casework manager would be looking out for at that stage. First, s/he would seek to identify cases where urgent interim action (e.g. suspension of the doctor from practice) appeared necessary for the protection of patients or otherwise in the public interest. After 2000, decisions about interim action were taken by the Interim Orders Committee (IOC). Members of staff could not refer a case direct to the IOC. The case had to go to a medical screener first. The casework manager would ensure that a case where interim action might be necessary went to a medical screener as soon as possible. Second, if the complaint raised a question as to whether the doctor's fitness to practise was seriously impaired by his/her physical or mental condition and this was the primary concern, the casework manager would forward the complaint to the Health Section. Subject to those matters, the casework manager would use the first part of the standard screening decision form (SDF) as a guide when making his/her decision and would record on the SDF the various steps in the decision-making process. The SDF was used to record decisions taken by staff as to whether a case should be referred to a medical screener. It also recorded the decisions taken by medical and lay screeners.

The Decision Whether or Not to Refer a Case to a Medical Screener

18.20 Rule 6 of the 1988 Professional Conduct Rules provided:

> **'(1) Where a complaint in writing or information in writing is received by the Registrar and it appears to him that a question arises whether the conduct of a practitioner constitutes serious professional misconduct the Registrar shall submit the matter to the President.'**

18.21 The functions of the Registrar, as set out in rule 6, were fulfilled by members of the GMC staff on his behalf. The medical screeners assumed the screening role previously performed by the President. In the case of R v General Medical Council ex parte Toth[1], Mr Justice Lightman described the role of the Registrar (in practice the GMC staff) in relation to rule 6 thus:

[1] [2000] 1 WLR 2209.

'At the first stage, the Registrar has a ministerial role: so long as there is a complaint (which connotes the making of some form of charge against a practitioner), the complaint is in writing and on its face the complaint raises a real question whether the conduct of a practitioner constitutes serious professional misconduct, he is duty bound to refer the matter to the screener.'

18.22 The first section of the SDF set out a long list of circumstances in which the GMC had decided that it would be appropriate for a casework manager to take a preliminary decision not to refer the case to a medical screener. These circumstances arose when:

(a) the complaint was not about a doctor

(b) the complaint related only to a minor motoring offence not involving drugs or alcohol

(c) the events complained of had occurred more than five years previously

(d) the complaint related only to fees charged for private treatment/service

(e) the complaint related only to a delay of less than six months in providing a single medical report

(f) the doctor's profession was incidental to the matter, e.g. a dispute between neighbours, one of whom happened to be a doctor

(g) the complaint related only to objections to the contents of medical reports or records where there was no suggestion that the doctor had acted unreasonably

(h) the 'complaint' was in fact an irrational/incoherent enquiry

(i) the complaint related only to patently frivolous/trivial non-clinical matters, e.g. the doctor was a few minutes late for a routine appointment

(j) the complaint related only to the fact that the doctor failed to take up a post following a verbal agreement to do so but gave two weeks' notice or more

(k) the complaint came from a third party where it was clear that the principal party did not want to pursue the matter, and there was no other reason for proceeding

(l) the complaint related only to a doctor's immigration status

(m) the complaint related only to the level or quality of service provided by a healthcare organisation where there was no suggestion that the doctor was directly responsible

(n) the complaint related only to removal from a GP list where there was no suggestion that the doctor's decision was unfair or contravened GMC guidelines

(o) the complaint related only to practice or departmental disputes where there was no suggestion that patients were being put at risk

(p) the complaint related only to failures in local complaints handling procedures

(q) the correspondence was a copy letter which did not specifically request GMC action

(r) the correspondent was explicitly seeking only an apology

(s) the complaint was anonymous and there was no reason to suspect that the doctor was an immediate threat to patients.

18.23 If any of these circumstances were judged to apply, the casework manager would close the case unless there was some other reason why the case should be considered by a medical screener. Any such reasons had to be recorded on the SDF. In deciding whether there was some other reason for referral to a medical screener, the casework manager would consider whether there was any cause to suspect that the doctor might be dangerous. The FTP Casework Manual gave guidance on the circumstances when this might arise, stating that a case should not be closed where it appeared to involve:

> **'a. persistent clinical errors;**
>
> **b. persistent failure to provide appropriate treatment/care;**
>
> **c. any single very serious clinical error or failure to provide appropriate care;**
>
> **d. any conduct which would fall into the category ''SPM by definition'' ... '**.

I shall explain the category 'SPM by definition' in Chapter 19.

18.24 The FTP Casework Manual made it clear that casework managers should be prepared to **'exercise discretion'** when assessing a case which did not meet any of the criteria set out above, but which nevertheless seemed to raise questions about whether the doctor was dangerous.

Referral Back for Local Action

18.25 If none of the circumstances listed at paragraph 18.22(a)–(s) applied, the casework manager would then go on to consider the source of the complaint. The casework manager would consider whether the complaint came from a private individual or from a person acting in a public capacity. A person acting in a public capacity was defined in the 1988 Professional Conduct Rules as:

> **'... an officer of a Health Authority, Health Board, Common Services Agency or Board of Governors of a hospital, or of a Local or Area Medical Committee or Family Practitioner Committee, or of a Hospital Medical Staff Committee or body exercising similar functions, or of a Licensing Body (that is, a University or other body granting primary United Kingdom qualifications), acting as such, or of a Government Department or local or public authority, or any person holding judicial office, or any officer attached to a Court, or the Solicitor to the Council'**.

In practice, the 'person acting in a public capacity' was usually a NHS trust or PCT. For convenience, I shall use the term 'public body' or 'referring body' instead of 'a person acting in a public capacity'.

18.26 If the complaint came from a public body, the casework manager would consider whether it appeared that all 'local procedures' had been exhausted before the complaint was referred to the GMC. If, for example, a PCT was reporting a doctor who was said to be practising to a generally poor standard, the GMC would expect the PCT to have attempted some form of remedial action (using its performance procedures) before referring the case on. If it appeared that local procedures had not, or might not have, been fully exhausted, the casework manager would contact the referring body and discuss how the case should be handled. The FTP Casework Manual stated:

> **'Where there is any question of an immediate danger to patients, the GMC may need to act. In other cases, efforts should be made to establish what local measures have been tried in order to resolve the doctor's problems – including whether the NCAA** (*National Clinical Assessment Authority*) **have been involved. One possible result of this type of discussion is that the referrer will withdraw the referral and take other measures locally first before referring back to the GMC if necessary.'**

18.27 The reference to the NCAA suggests that the requirement for public bodies to exhaust all local procedures before the GMC would take action applied primarily to cases involving potential poor performance by a doctor. Mr Marshall told the Inquiry that, sometimes, a three-way discussion took place between the GMC, the NCAA and the referring body. He said that, in all cases where the complaint came from a public body (not just where there was uncertainty as to whether local procedures had been exhausted), there was personal contact with the referring body in order to discuss how the case should be dealt with.

18.28 Where the complaint came from a private individual, the casework manager would consider whether that person had made use of any available complaints procedures before approaching the GMC. In general, the GMC would not consider a complaint from a private individual unless local complaints procedures had been exhausted. If the complaint related to a doctor working in the NHS, the casework manager had to consider whether there was any reason to believe that the complainant had referred the matter to the appropriate NHS complaints body and had exhausted that body's complaints procedures before making a complaint to the GMC. If the complaint related to a doctor in private practice, the individual would be expected to have made use of any available complaints procedures, including reference to the National Care Standards Commission (NCSC, now part of the Commission for Healthcare Audit and Inspection, which is known as the Healthcare Commission). There were other local complaints procedures to which certain complainants were expected to direct their complaints in certain circumstances, but I shall refer only to those relating to NHS and private treatment. If it did not appear that the individual had made use of the available complaints procedures, the case would be closed at that stage unless there was any cause to suspect that the doctor was dangerous. If there was no cause to suspect that s/he was dangerous, the complainant would be advised to direct the complaint to the appropriate complaints handling body.

18.29 It should be noted that the test applied by the staff at this stage (in cases where it appeared that the local complaints procedures had not been exhausted) was not whether (in the words of rule 6) **'a question arises whether the conduct of a practitioner constitutes**

serious professional misconduct'. The test applied by the staff was the higher test of whether there was cause to suspect that the doctor was dangerous. In other words, even if a question did arise as to whether the conduct of a practitioner amounted to SPM, the case would be closed unless there was cause to suspect that s/he was dangerous. It appears to me that the practice that I have outlined above was unlawful, given the mandatory wording of rule 6. The criteria which GMC staff were instructed to use when deciding whether there was any cause to suspect that the doctor was dangerous are set out at paragraph 18.23. I shall discuss the practice of referring complaints back to local complaints procedures in greater detail later in this Chapter.

18.30 Communication with an individual complainant at this stage, and at all other times up to and including the consideration of a case by the Preliminary Proceedings Committee (PPC) and its referral to the PCC, would in general be by letter. It would be unusual for the GMC to initiate any telephone contact.

18.31 If there was evidence that the local complaints procedures had been used and exhausted, or if they were not available because the relevant time limits had expired, the casework manager would go on to consider the next stage in the decision-making process. The FTP Casework Manual advised that, if the individual concerned had referred his/her complaint to local complaints procedures but was dissatisfied with its progress through those procedures, the GMC should usually take the complaint forward, rather than try to force the individual to persevere with a process with which s/he was unhappy.

Initial Screening

18.32 At this point, the casework manager had the option of submitting the case to a medical screener for what was known as 'initial screening'. This was a fast track system for cases which the GMC staff believed could not amount to SPM or seriously deficient performance (SDP) but where the complaint was about treatment or other matters involving clinical judgement, so that some input from a medical practitioner was considered necessary before a final decision to close the case could be taken. If the medical screener agreed that the case should be closed, the confirmation of a lay screener was necessary before this could be done. I shall consider this process of initial screening when I go on to examine the screening process in Chapter 19.

Preparation of the Case for Referral to the Medical Screener

18.33 If a case passed through the initial triage (and initial screening, where appropriate) and was to be taken forward, it was allocated to a caseworker who would then be responsible for preparing the case for consideration by a medical screener. The casework manager would have given an indication of any preparatory steps to be taken. Mr Marshall said that these steps might include the obtaining of medical records or an expert opinion, if it were obvious that these were required. The caseworker would write to the complainant (if a private individual) and would seek his/her consent to disclose the details of his/her complaint to the doctor who was the subject of the complaint. If consent was forthcoming, the complaint would be disclosed and the doctor's response invited. If not, the case would be closed unless, as the FTP Casework Manual stated, **'the public interest requires that**

... (*the GMC*) **... pursue the case irrespective of the enquirer's loss of interest'**. Consent to disclose was presumed when a complaint was made by a public body.

18.34 The caseworker would also assess the available evidence and would consider whether there was any further information which could be obtained that would be of assistance to the medical screener in deciding what action to take in respect of the complaint. I shall deal with the gathering of information before screening in more detail later in this Chapter.

18.35 Before submitting the case to the medical screener, the caseworker would prepare a memorandum, summarising the nature of the allegation, the evidence available in support and, usually, the views of the caseworker as to the appropriate course of action. If the caseworker's view was that the case was likely to be sent to the PPC, s/he would prepare a draft letter to be approved by the medical screener and then sent to the doctor after screening. The letter would inform the doctor of the charges which s/he might have to face.

Later Closure of a Case

18.36 It sometimes happened that the first communication received by the GMC did not make clear the precise nature of the complaint. Clarification might have been needed in order to ascertain this. Once the matter had been clarified, closure of the case might have been appropriate on one of the grounds set out at paragraph 18.22(a)–(s). Closure of the case might also have been appropriate for other reasons which had become known or had arisen while the complaint was under consideration. Accordingly, it was possible for staff to close a case without reference to a medical screener at any stage after the initial assessment or triage and before screening. The grounds for doing so were (in addition to those referred to at paragraph 18.22(a)–(s)) that:

- the complaint had been withdrawn
- the doctor could not be identified despite all reasonable efforts to identify him/her
- the doctor had died
- there had been no response from the doctor and his/her name had been erased from the register under section 30(5) of the Medical Act 1983, whereby the name of a doctor who fails to respond within six months to an enquiry about his/her address may be erased.

18.37 In the past, the staff would also close a case when the complainant refused to provide a statutory declaration in support of his/her complaint. A statutory declaration is a formal affirmation that the contents of a written statement are true. It must be made in the presence of a solicitor or of a person within other limited categories. However, the GMC's requirement for a statutory declaration in support of a complaint was abolished in November 2002. It applied only to private individuals. No statutory declaration was required from a person acting in a public capacity.

Earlier Practice

18.38 The system for the initial stages of processing conduct cases which I have described above was of relatively recent origin. Until the late 1990s, the way in which cases were

processed was far less structured. Little data was stored on computer and staff did not have available to them the detailed guidance and the standard forms which were developed during the period between 1999 and 2003.

Changes in Practice after December 2003

18.39 Some changes in office practice have occurred since the Inquiry hearings. As I have said, in May 2004, the FTP Casework Manual was replaced by the FTP Investigation Manual. At the same time, the standard CDF and SDF were replaced by the initial processing and assessment form. It is unnecessary for me to refer in any detail to the contents of these documents, which will be superseded by new guidance and forms prepared for the use of staff when implementing the new FTP procedures.

The Procedure for Dealing with Convictions

18.40 The procedure adopted when a conviction was notified to the GMC was rather different from the procedure following the making of a complaint about a doctor. The 1988 Professional Conduct Rules (as amended in November 2002) provided that all convictions, with the exception of two classes of case, must be referred to a medical screener. The first exception related to minor motoring convictions (i.e. motoring convictions not involving drugs or alcohol). Where information was received about a conviction which the Registrar considered to be a **'minor motoring offence'**, the case should not proceed further. Such cases would be closed in the office without reference to a medical screener. The second exception related to conviction cases where a custodial sentence (but not a suspended sentence) had been imposed. After November 2002, these were referred direct to the PCC for hearing, unless the staff (exercising the powers of the Registrar) were of the opinion that a direct referral would not be in the public interest.

18.41 If, following a criminal investigation, no charges were brought or charges were dropped, or if a criminal trial resulted in an acquittal, the GMC might, nevertheless, wish to pursue the case if issues about the doctor's fitness to practise had been raised in the course of the criminal investigation. This might also be the case if a criminal court had imposed an absolute or conditional discharge (which, as I have explained, would not have ranked as a 'conviction'), or if the doctor had been cautioned for a criminal offence. In that event, the case would follow the same procedure as that for a complaint.

18.42 After 2000, on receipt by the GMC of information about a conviction, or about an ongoing criminal investigation or ongoing criminal proceedings affecting a doctor, a casework manager would give urgent consideration to whether it would be appropriate for the case to be referred to a medical screener for possible referral to the IOC. However, before 2000, the GMC had no power to make interim orders in respect of a doctor who was being investigated or was facing trial for a criminal offence. This *lacuna* in the GMC's powers was rectified as the direct result of the GMC's inability to suspend Shipman from practice in 1998 when it was discovered that he was under investigation for murder. On reflection, it is surprising that, until Shipman's case, the GMC had apparently not felt the need for such a power and had not previously requested its provision. I refer to this matter in more detail in Chapter 20.

Audit

18.43 In the period from 1996 to 2001, the annual number of convictions reported and complaints received by the GMC rose from about 1500 or 1600 to 4500. The GMC office had considerable difficulty in managing this increased workload and this resulted in lengthy delays in dealing with cases. Mr Marshall told the Inquiry that, by 2000, it had been recognised that the GMC had no effective way of managing cases. It was reliant on caseworkers to report any problems that arose. Many of the cases in the system had been open for a long time without any real action being taken on them. An exercise, known as the Case Review Audit and Management Information Project, was undertaken. Mr Marshall managed the Project for 12 months. In effect, it amounted to a 'spring clean' of open cases. It involved considering whether further action was necessary and reviewing cases. As a result of the exercise, many cases were closed. At the same time, an audit process was instituted, whereby 10% of cases processed by the GMC staff were audited in an attempt to discover whether proper procedures had been followed and whether those procedures could be improved. That work led to the implementation of a structured work flow procedure for screening and to the preparation of the FTP Casework Manual and of other instructions for caseworkers. In time, the case review element of the Project ceased, as the backlog of open cases was dealt with. However, audit continued and was carried out by a newly formed Fitness to Practise Directorate (FPD) audit team.

18.44 In July 2000, service standards came into effect for the first time. These service standards identified periods within which certain elements of the FTP procedures should be completed. Targets for completion of cases within the service standards were set and regular reports of performance against the standards were required by the Council.

18.45 From January 2003, the FPD audit team carried out audits of random samples of cases at four different stages of progress. These were described as 'screening audits' (presumably because they were audits of work done in the Screening Section). They did not, however, relate to the work of the screeners. One hundred and ten cases every four weeks were selected for audit. The purpose of the audit was to check that all the appropriate procedural steps had been taken. In particular, a check was made to ensure that service standards had been met, that the case file had been well ordered and that the database had been appropriately maintained to reflect the progress of the investigation. If errors were found, auditors identified any appropriate corrective action which should be taken, and the execution of that corrective action was also the subject of audit.

18.46 Decisions to close a case at the triage stage were also audited and any errors taken up with the relevant casework manager. Until the end of 2003, 10% of cases closed at triage were audited. This was subsequently increased to 50%. During December 2003, 144 cases were closed at triage. One half (72) of those cases were audited. Four cases were identified as having been closed incorrectly (although, in one case, after further discussion with the casework manager, it was decided that his action had been justified). Three cases were reopened. Two of those cases had been inappropriately referred back to local complaints procedures. One (a sensitive case involving a complaint by a father whose children had been removed from his care after a court hearing at which the doctors complained of had given expert evidence) had been closed on the ground that the

complainant was not suggesting the doctors had acted unreasonably. In fact, although it appears that he had not said this in so many words, it was clear that he was alleging unreasonableness. There were nine further cases where an inappropriate reason for closure had been recorded on the SDF, although the auditor was satisfied that the closure was justified for other reasons. It occurred to me that, in view of the fact that three of the 72 cases examined were found to have been incorrectly closed, it would have been wise to examine the other 72. However, I do not think that that was done.

Advice to Refer a Complaint to Local Complaints Procedures

18.47 I have said that, in general, the GMC was not in the past prepared to consider a complaint from a private individual about medical treatment unless and until any complaints procedures available locally had been exhausted. Instead, complainants would be advised to pursue the complaint through local procedures. Until October or November 2002, the policy did not extend to complaints about private treatment, only to complaints relating to NHS treatment. After that time, however, complaints about private treatment were also referred back to the complaints procedures of the private doctors or organisations concerned.

Criticism of the Policy

18.48 The policy has been the subject of controversy for many years. In 1988, Mrs Jean Robinson, then a lay member of the GMC, drew attention to it in her publication 'A Patient Voice at the GMC'[2]. She complained that the **'hidden policy'** of the GMC for the previous 15 years had been that complaints about NHS treatment made by private individuals were not considered by a GMC screener but were instead referred straight back to the complainant with advice to pursue the complaint through NHS complaints procedures. The GMC would consider such complaints only if they had been investigated and found proved by a NHS authority. Instead of deciding itself in which cases it should act, the GMC relied on NHS authorities to report, at the conclusion of the complaints procedures, any case which appeared to them serious enough to warrant the attention of the GMC. Mrs Robinson expressed concern that this policy was adopted in all cases involving NHS complaints, no matter how serious the allegation against the doctor and no matter whether a question of SPM did or did not arise. Mrs Robinson questioned whether the policy complied with the GMC's Rules. The relevant rule was rule 6 of the 1988 Professional Conduct Rules, the terms of which I set out at paragraph 18.20.

18.49 Mrs Robinson observed that there were arrangements in place for reports to be made to the GMC by NHS authorities in the case of complaints against GPs, but not in respect of complaints against hospital doctors. She pointed out that, at the time she was writing, NHS hospital complaints procedures were unsatisfactory and rarely resulted in a report to the GMC. She said that, as a result, **'hospital doctors have been largely immune from GMC action on clinical standards'**. Mrs Robinson was also critical of the procedures for dealing with complaints against GPs. I have described in Chapter 6 the complaints

[2] Robinson, Jean (1988) 'A Patient Voice at the GMC'. London: Health Rights.

procedures which were in force at the time when Mrs Robinson was writing and it is clear that her criticisms were justified.

18.50 Briefly, the position was that complaints about a breach by a GP of his/her terms of service were heard by medical service committees (MSCs) of family practitioner committees (FPCs). Reports of all cases in which a breach had been found proved were sent to the Secretary of State for Health (SoS), who would report appropriate cases to the GMC, after taking the advice of the Medical Advisory Committee. From 1992, the SoS delegated his/her powers to the Family Health Services Appeal Unit (FHSAU) and, from 1996, the FHSAU's functions were exercised by the Family Health Services Appeal Authority (FHSAA) (later the FHSAA (Special Health Authority)). The Department of Health (DoH) issued a list of criteria setting out the types of case that should be reported to the GMC. These were cases involving a neglect or disregard of professional responsibilities to patients, cases where there had been a NHS Tribunal decision that a doctor's name should be removed from the FPC's medical list, and other cases involving irregular certification, improper charging or claims for fees or canvassing or gaining of patients by unethical means. In addition, advice was given to consider reporting cases of misconduct which had been **'seriously prejudicial to the medical care of patients'**. There was also reference to the possibility that cases of dishonesty by doctors might amount to SPM and should be reported. After 1992, family health services authorities (FHSAs), the successors to FPCs, were encouraged to report appropriate cases directly to the GMC (rather than to rely on the FHSAU/FHSAA to do so).

18.51 Despite the list of criteria issued by the DoH, which was in existence at the time of Mrs Robinson's concern, it was not at all clear that all proven complaints that might amount to SPM would necessarily find their way back to the GMC. Mrs Robinson's contention was that the chances of a GP being reported to the GMC following a complaint to his/her FPC were slim. She pointed out that NHS complaints procedures could take a long time to be completed. Even if a complaint was eventually referred back to the GMC after completion of the procedures, there was often a long delay before this occurred. A doctor who was dangerously incompetent might have caused further damage to patients while the complaint was being processed.

18.52 Mrs Robinson pointed out that some patients and their families might be unequal to the task of pursuing a complaint through NHS complaints procedures and some might find that they were already outside the time limit (then only eight weeks) for doing so. Some might not realise that it was necessary for them to follow the formal complaints procedures (as opposed to the informal conciliation procedures which were being encouraged at the time) in order to have any prospect at all of their cases being referred back to the GMC. At the time when Mrs Robinson was writing, the standard letters written by the GMC to complainants advised them that they could bring their complaints back to the GMC at the conclusion of the NHS complaints process. Previous versions of the letter had not contained that information. Mrs Robinson said that the standard letter had been amended at her insistence. Recipients of earlier versions of the letter might, however, have believed that they could not approach the GMC again, even if they had received no satisfaction from local complaints procedures.

18.53 The effect of the GMC's policy was to make it likely that some cases of seriously substandard clinical practice would not be considered by the GMC. This could occur because complainants, disappointed at the initial response from the GMC, gave up and did not pursue their cases further. But, even if they pursued their complaint locally, it could founder in a number of ways. If the complaint was found proved, it might not be referred to the GMC by the relevant NHS authority. Even if it were referred back to the GMC, two to three years might have passed, after which time witnesses might be no longer available or might be unwilling to give their evidence for a second time. In such cases, disciplinary action by the GMC would be impossible. Furthermore, throughout that time, the doctor would have been free to treat patients.

18.54 Mrs Robinson observed that the GMC sought to justify its policy by reference to the stringent time limits within which complaints against GPs had to be made. It was said that, by the time the GMC had considered and rejected a complaint, the complainant might have lost the opportunity to complain locally. It was therefore better for him/her, the GMC suggested, to be referred to the local procedures immediately. Mrs Robinson pointed out that it would be perfectly possible for the GMC to refer a complaint to a medical screener for consideration, while at the same time writing to the complainant to inform him/her of the time limits for making a complaint locally. Thus, the complainant's position could be satisfactorily safeguarded. When Mrs Robinson's suggestion was put to Mr Howes, who was employed in the Conduct Section more or less continuously between 1980 and 1994, he told the Inquiry that the perception within the GMC at the time Mrs Robinson was writing was, rightly or wrongly, that to start two procedures simultaneously would have been a 'nonsense' and unfair to doctors. I feel bound to observe that it does not appear to have been uppermost in the GMC's mind that what was required was a procedure that would best protect patients, while also being fair to doctors. In any event, it appears that the GMC sometimes did allow two sets of procedures to be in operation at the same time. Mr Townsend, Head of the Conduct Section from 1994 until 1998, told the Inquiry that there were occasions when NHS authorities reported to the GMC serious cases with which they were currently dealing in their complaints procedures. The GMC kept open the possibility of starting its own procedures to run in parallel with local procedures if the public interest demanded it. It may be that the situation described by Mr Townsend did not apply in the 1980s and early 1990s.

Evidence to the Wilson Committee

18.55 Until 1993, and despite the serious concerns raised by Mrs Robinson, the system continued whereby a member of staff would direct complaints about NHS treatment back to complainants without referring them to a medical screener. GMC statistics show that, in the year to 31st August 1993, 160 complaints (i.e. about 10% of all complaints received by the GMC) were dealt with in this way. In July 1993, a pilot scheme was introduced whereby such complaints were referred to a medical screener for consideration, rather than being immediately referred back to the complainant by members of the GMC staff. At the time the change was made, the reason behind it was said (in the Annual Report of the PPC presented to the Council in November 1993) to be that the time limits within which complaints could be made to NHS bodies had been relaxed, giving more time for the GMC

to deal with complaints. This was plainly not the reason, as the change in time limits had taken place in 1990 and extended the time limits only from eight to thirteen weeks. In any event, Mr Scott told the Inquiry that the change of system resulted from the fact that, in 1993, the GMC was invited to submit evidence to the Independent Review Committee, chaired by Professor (later Sir) Alan Wilson (the Wilson Committee). The Wilson Committee was considering reform of the NHS complaints procedures. The preparation of evidence for submission to the Wilson Committee caused members of the GMC to reflect on its existing practice of allowing members of staff to refer cases back to complainants without the intervention of the medical screeners, and to change it. It may be that the change resulted from concerns as to whether the policy then in operation complied with the GMC's Rules. In my view, it did not. Rule 6 of the 1988 Professional Conduct Rules required the Registrar (in practice, a member of staff) to send to the President (medical screener) any complaint which appeared to raise a question of SPM. It was not for members of staff to close such cases themselves after advising complainants to use local procedures.

18.56 In September 1993, the PPC sent a memorandum of evidence to the Wilson Committee on behalf of the GMC. The memorandum discussed the GMC's policy of referring complaints to the NHS complaints procedures, a policy which was described by the PPC as **'helpful to complainants'**. The memorandum described how complainants to the GMC were informed, where appropriate, of the existence of the NHS complaints procedures and were offered the opportunity of using those procedures and/or of writing again to the GMC. It observed that the majority of such complaints then proceeded under the NHS complaints procedures. In fact, the PPC had no means of knowing that. The GMC took no steps to find out what subsequently happened to cases which had been referred back to complainants. All the PPC could have known was that the majority of complainants did not approach the GMC again.

18.57 The memorandum made clear that the GMC wanted to retain the ability, if it regarded it as appropriate to do so, to proceed with a complaint that was reported to it, without referring it to local complaints procedures. It would do that, it was claimed, if the complaint seemed to raise a question of SPM or of serious impairment of health that the GMC had a statutory duty to consider and act upon. That statement of current practice was not accurate because, as I have indicated, staff did not refer to medical screeners all complaints from individuals that appeared to raise a question of SPM but only those in which the local complaints procedures had been completed. If the local complaints procedure had not been completed, the case would be accepted into the GMC procedures only if it appeared to the GMC that the doctor was a risk to the public.

18.58 The PPC expressed concern to the Wilson Committee that NHS bodies were not referring to the GMC all cases which should have been referred. The memorandum pointed out that only one or two complaints which had been decided by MSCs had been referred direct to the GMC by FHSAs. FHSAs sometimes dealt with serious MSC cases without referring them to the FHSAU. Only one case which had been dealt with by the NHS Tribunal had been reported to the GMC in three years. Referrals from hospital authorities had been in single figures in 1990, 1991 and 1992. The memorandum said that the GMC had been expressing concern since 1987 at the small numbers of doctors being reported by hospital authorities. In evidence to the Inquiry, Mr Townsend said that the lack of effective

disciplinary procedures in hospitals was a source of concern during his time in the Conduct Section between 1994 and 1998. Hospital doctors tended to be dismissed for misconduct without a referral to the GMC. Moreover, he said that there was concern within the GMC that the policy of requiring complaints to be directed to local complaints procedures put the onus on complainants and NHS authorities to trigger the revival of the cases at the GMC. It was felt that this was inconsistent with the GMC's stated purpose, which was to protect the public interest.

18.59 The PPC's memorandum to the Wilson Committee also referred to the delays (said to be as long as three years on occasion) which could occur before a complaint about NHS treatment was resolved locally and its outcome reported to the GMC. Reference was made to the adverse effects on the evidence available to the GMC and examples of particularly lengthy delays were given. The memorandum referred to repeated representations which had been made by the GMC over a period of 17 years about excessive delays in NHS complaints procedures and about the effects of those delays. During that time, the memorandum said, the delays had got worse, not better.

18.60 The memorandum asked the Wilson Committee to consider means of avoiding protracted delays. The PPC requested that FHSAs should be reminded of their duty to refer appropriate cases to the GMC. There was also a request that mechanisms should be established for the reporting to the GMC of cases involving hospital doctors where it appeared that a question of SPM arose.

18.61 It is clear that, by 1993 at least (and probably long before), the GMC fully recognised the deficiencies of the NHS complaints procedures. It was also recognised that, as a result of those deficiencies, cases of SPM that should have been referred back to the GMC were not reaching it. Those cases that were eventually referred to the GMC, after passing through the NHS complaints procedures, were not arriving until long after the events to which the complaints related. Yet, despite the fact that Mrs Robinson had, in 1988, drawn its attention to the effect of the deficiencies, the GMC had persisted in its policy of sending cases back for referral into local procedures without considering whether or not they raised a question of SPM. Even in 1993, when the effects of the deficiencies of the complaints system were plainly recognised, there does not seem to have been any recognition of the fact that some complaints which had come to the GMC and been referred back to the complainant might not have gone into the NHS complaints procedures at all and may consequently have been lost to the regulatory system altogether.

The Change of Practice in 1993

18.62 The change of practice, which was first piloted in July 1993 and continued thereafter, meant that all complaints about NHS treatment were referred in the first instance to a medical screener. When the change was made, it was said to be intended that the medical screener would decide whether the complaint raised a question of SPM and that only if s/he thought that it did not would the complainant be advised to direct the complaint to local complaints procedures. That intention was expressed in the Annual Report of the PPC, presented to the Council in November 1993. Had that intention been put into effect,

GMC practice would then have been in compliance with rule 6 of the 1988 Professional Conduct Rules.

18.63 Despite the contents of that Annual Report, it is clear from the findings of the PSI, which carried out an analysis of complaints received by the GMC in the 12 month period from September 1993, that the intention claimed in the Annual Report had not been carried into effect. The PSI team found that medical screeners were applying a threshold higher than SPM for the retention of cases by the GMC. In describing the procedures, the 1996 PSI Report stated:

> **'... it should be noted here that the GMC receives frequent complaints which it feels should more appropriately be dealt with initially by other bodies, for example, Family Health Services Authority ... a Health Authority, an NHS Trust, the Prison Medical Service or the Mental Health Act Commission. The question of whether there is a *prima facie* case of serious professional misconduct may or may not arise in these cases, but the GMC does not usually pursue a complaint in these circumstances but suggests that the complainant takes it up initially with ''a more appropriate body''. The discretion of the medical screener is exercised in cases where it is felt that there could be risk to the public if the GMC failed to initiate action at the same time as suggesting that the complaint should be made to another authority.'**

18.64 It seems that the PSI team had been told that the test being applied by the screeners was not whether a complaint raised a question of SPM but whether it gave rise to a risk to the public. Provided that no such risk was considered to arise, the complainant would be advised to direct the complaint to the local complaints procedures, whether or not the case raised a question of SPM. The concurrence of a lay screener was not required when a medical screener agreed that a case should be referred back to be pursued through local procedures. This was because the case was not classified as having been formally rejected by the GMC. It should have been so classified because, in reality, the case had been closed. Of course, there was a possibility that the complainant might bring the case back but, if s/he did not, the GMC would do nothing more. The effect of this incorrect classification was that the possibility that the lay screener might decide that the case should remain in the GMC was lost. In short, the only change that had occurred as a result of the consideration of the GMC's procedures undertaken at the time of the submission to the Wilson Committee was that the 'risk to the public' test was applied by screeners, rather than by GMC staff. No doubt many Council members believed (relying on the 1993 Annual Report) that the procedures in operation were compliant with rule 6. In fact, they were not, because the medical screeners were not applying the correct statutory test. The medical screeners were members of the GMC and should have realised that the reality was that the process was not as described in the Annual Report and was not compliant with the Rules. I shall refer further to the findings of the PSI team later in this Chapter.

18.65 If there had indeed been a change in the test to be applied as from about November 1993, one might have expected to see a significant reduction in the proportion of complaints being referred back to complainants with advice to pursue them through local

procedures. However, such figures as are available suggest that there was no such reduction. In the year to August 1992, the GMC received information about 1300 convictions and complaints; 185 of those were referred back to be pursued through local procedures. In the year to August 1993, 1612 convictions and complaints were received, of which 160 were referred back. In 1994, 1626 convictions and complaints were received and 192 cases were referred back to be pursued through local complaints procedures. These figures would tend to confirm that the test applied before and after November 1993 was the 'risk to the public' test and that the medical screeners took broadly the same view on risk as the staff had done before the change.

18.66 The practice of referring a case back to be pursued through local procedures unless the facts suggested that there was a risk to the public seems to have operated even where the doctor had a previous finding of SPM against him/her. In one case examined by the Inquiry, Dr JG 03 was convicted of perverting the course of justice and was later found guilty of SPM. He had given a contraindicated drug to an asthmatic patient in the early 1990s and had lied at the coroner's inquest, claiming that he was unaware from the records that the patient suffered from asthma. It was later discovered that he had falsified the records and he was prosecuted. The GMC dealt with both matters and imposed conditions on his registration for one year. A further complaint was received about this doctor seven years later, but the complainant was advised to pursue the complaint through local complaints procedures. There is no sign in the GMC file that the progress or outcome at local level of the more recent complaint was followed up.

The Guidance Contained in the 1994 Training Manual

18.67 The Training Manual, which was compiled in 1994 by Mr Howes (the 1994 Training Manual), stated that NHS treatment (or lack of it) was primarily the responsibility of the local NHS authority and that complainants should be advised **'in the first instance'** (*emphasis in the original*) to direct their complaints to the appropriate health authority (HA) or FHSA. The 1994 Training Manual gave a number of reasons for this procedure. The first related to the time limits governing local complaints procedures. If an individual was to have his/her complaint considered under those procedures, s/he had to move fairly quickly. The second reason was the speed with which local investigations could begin, even if (as was acknowledged) they took **'some time to complete'**. Mr Howes said that the reference to the speed with which local investigations could begin related to the time when a doctor would be notified of a complaint which had been made against him/her. Under NHS procedures, s/he would be notified early on, in accordance with specified time limits. Under the GMC procedures at that time, the doctor would not be notified (and the 'investigation' would not start) until the medical screener had taken a decision to refer the case to the PPC. That, it was said, could take **'some time'**. In fact, at this period, there was no significant delay within the early stages of the GMC procedures. This was an attempt to use the possibility of delay at the GMC as a justification for sending the case into local procedures. In addition, the FHSA or HA would have, it was said, much greater access to potential witnesses and relevant records. The 1994 Training Manual also made the point that complaints about hospital treatment often involved many factors (e.g. the behaviour of nurses) which lay outside the province of the GMC.

18.68 The 1994 Training Manual reminded staff that complainants were under no obligation to make a complaint first to the local body, although this was said to be **'in most respects desirable and appropriate'**. If a complainant insisted that his/her complaint should be considered by the GMC before being referred to local complaints procedures, the case should be referred to a medical screener for a decision on whether the GMC should **'intervene'**.

18.69 In describing the action to be taken when a complaint was reported to the GMC after completion of the NHS complaints procedure, the 1994 Training Manual acknowledged that such cases might reach the GMC as long as two or three years after the events which had given rise to them. By that time, the patient concerned had sometimes died. Since, if the complaint were to be referred to the PCC, a further hearing would be required, the fact that the patient was not available to give evidence could obviously cause difficulty in a case which depended on his/her evidence. It might not be possible for such a case to proceed.

18.70 The 1994 Training Manual made clear that, when a complaint had been referred to the GMC by a FHSA or a HA, following completion of its complaints procedures, the GMC would almost always take some form of action, whether by referring the cases to the PPC (and, possibly, from there to the PCC) or by issuing a warning to the doctor. In cases where there had been an adverse finding by a MSC, if it was the first time that a doctor had been found in breach of his/her terms of service and the doctor had no known previous disciplinary history, the 1994 Training Manual indicated that the case could probably be dealt with by means of a warning. In a second or subsequent case, however, formal disciplinary action might be justified, depending on the circumstances of the case and whether evidence was still available. However, when the adverse findings of two MSCs concerning Shipman were referred to the GMC by the FHSAU in 1994, no action at all was taken. I shall describe what happened on that occasion in Chapter 19.

18.71 After 1993, when a complaint about NHS treatment was received and the GMC staff considered it appropriate to refer it back to be pursued through local complaints procedures, the staff would submit to the medical screener a memorandum (much shorter and less detailed than that usually provided when a case was to be screened), setting out the reasons for recommending that the complaint should be referred to local NHS complaints procedures. Attached to the memorandum would be a draft standard letter to the complainant. Examples of the standard letters in use in 1994 were contained in the 1994 Training Manual. The letter would inform complainants that primary responsibility for considering complaints about treatment (or lack of treatment) lay with the local NHS body. It would suggest that the complainant should make his/her complaint in the first instance to the appropriate NHS body. The letter would advise the complainant of the time limit for local complaints and would enclose a photocopy of the complainant's original letter to the GMC, so that the complainant could use it, if s/he wished, when writing to the relevant NHS complaints body. The letter would inform the complainant that, if his/her complaint were upheld, an official report would automatically be sent to the GMC if **'it is considered** (*i.e. by the NHS*) **that subsequent disciplinary action by the Council may be justified'**. The complainant would be told that s/he might write again to the GMC when the investigation

by the local complaints body was complete. At that point, the screener would be willing to consider the matter further, even if the complaint had not been upheld. The letter stated:

> **'The Council does not usually consider a case until after any appropriate local investigation, because there are practical and legal difficulties about holding two inquiries into the same events at the same time.'**

18.72 It might have been undesirable and wasteful of resources to have two concurrent enquiries (and it may have been considered 'unfair to doctors') but I am unsure what the **'legal difficulties'** would have been. The letter went on to tell the complainant that if there was some **'particular reason'** why s/he did not wish to complain to the relevant NHS authority, or if the authority was for some reason not able to investigate the matter, s/he could write again to the GMC which would consider the complaint further. The telephone number of a service providing general advice on making a complaint about a NHS doctor was given.

18.73 Although the letter was helpful in tone and content, it nevertheless placed the onus for pursuing the complaint through the NHS complaints procedures squarely on the complainant. This was at a time when the GMC was fully aware of the shortcomings of the local complaints procedures and of the fact that few cases found their way back to the GMC after being referred to those procedures. The letter contained no suggestion that the GMC might itself pass on the complaint to the NHS complaints body concerned. Nor was there any follow-up procedure to ensure that a complaint had been reported to the appropriate authority or to ascertain the outcome. The complaint might have been about unacceptable clinical practice which, if repeated, could have caused harm to other patients. Yet, if the complainant chose not to pursue the complaint further, the NHS body responsible for the doctor (in the case of a GP, the FHSA) might have remained wholly unaware that an incident had occurred or that patients might be at risk from the doctor. The GMC would take no steps to inform it.

The Work of the Policy Studies Institute

18.74 The 1996 PSI Report recommended that the GMC should review its role and responsibilities when dealing with cases where complainants were advised to direct their complaints to a local NHS body. It made the point that the GMC would often not be in a position to know, at the stage when the advice was given, whether the complaint was likely to amount to SPM. The PSI team examined a sample of 134 complaints in which, during the year to August 1994, the GMC had advised complainants to refer their complaints to a more appropriate body. They found that the complaints included complaints about dissatisfaction with treatment, about failure to take steps to make a diagnosis and about failure to diagnose and treat patients. One was an allegation of 'criminal irresponsibility' resulting in the death of a patient. The fact that these complaints (particularly one such as the last-mentioned) had not been pursued immediately by the GMC was a source of understandable concern to the PSI team.

18.75 Professor Allen, who led the PSI team, told the Inquiry that she and her colleagues were concerned that these cases appeared sometimes to be 'lost' to the GMC. They noted the onus being put on patients and their families to pursue the complaints. If they decided not

to pursue them, the complaints would just disappear. The PSI team also expressed concern at the failure of the GMC to follow up complaints so as to ascertain their outcome.

18.76 In 1996, the NHS procedures governing complaints about GPs changed. The procedures in operation from 1996 are described in Chapter 7. Professor Allen told the Inquiry that, under the pre-1996 procedures, the process of making a complaint about a GP locally was relatively easy. The complainant would complain to the FHSA. The complaint would be logged and considered and, if it appeared to relate to a breach of terms of service, it would be referred to the chairman of the MSC and the process would be underway. Under the 1996 procedures, however, complaints went to the GP practice in the first instance and many were 'resolved' there. The PCO would have no idea what the nature of the complaint or the 'resolution' was. The process of securing an independent review panel (IRP) hearing under the new procedures was, she said, 'incredibly convoluted', as a result of which comparatively few hearings were held. Professor Allen believed that some patients were discouraged from complaining because of the requirement to approach the GP practice first, a concern that was highlighted in the research carried out in the late 1990s, which I described in Chapter 7. In short, complaints about a GP were not investigated by a NHS body; the PCO had neither the power nor the resources to do so.

18.77 After 1st April 1996, the NHS complaints procedures were, for the first time, separated from the disciplinary procedures for GPs. Previously, a patient complaint might lead to a finding of a breach of the GP's terms of service and to a sanction. After 1996, even if the findings of an IRP hearing showed that a GP had been in breach of his/her terms of service, disciplinary proceedings would not automatically follow. The disciplinary process was cumbersome and very few disciplinary hearings took place at all. Also, there was a change of culture and PCOs preferred to take a remedial approach to any shortcomings in a GP's practice. After 1996, the effect of GMC policy was, therefore, to refer a doctor from a system designed to discipline doctors where appropriate (i.e. the GMC procedures) to a complaints system, the primary purpose of which was to 'resolve' the complaint, preferably by conciliation. Any recognised shortcomings in the doctor's practice were likely to be dealt with (if at all) by remediation rather than disciplinary action and the prospects of a prompt referral back to the GMC were remote. The illogicality of that situation, and its even greater potential for allowing complaints to be 'lost', does not appear to have been appreciated by the GMC.

The 1997 Screeners' Handbook

18.78 At the time of the production of the Screeners' Handbook in 1997, medical screeners (rather than the GMC staff) were still being required to consider what should happen to complaints where the likely outcome was referral to NHS complaints procedures. The Screeners' Handbook contained the following advice:

> **'If, in a complaint about NHS treatment and after appropriate inquiries have been made, it appears that**
>
> **a. The pursuit of the complaint through the NHS procedures would be the most effective way to produce information which the GMC requires**

to consider the case further and without which further GMC action would be difficult or impossible, or

b. There is no immediate threat to patient safety and it would be fairer to the doctor not to make him or her face two sets of proceedings simultaneously,

the screener may decide that the complainant should be asked to consider making a complaint through the NHS complaints procedures (or to continue to pursue one already lodged), and invited to approach the GMC once that process has been completed, whatever the outcome.'

18.79 It is to be noted, first, that the test to be applied by the medical screeners was one of **'no immediate threat to patient safety'**. This was similar to the test which had previously been applied by the medical screeners, namely whether there could be a risk to the public if the GMC did not act immediately. Second, it is clear to me from the evidence, particularly that of Dr Korlipara, that the screeners assumed that the pursuit of a complaint through NHS complaints procedures would, in all cases which did not reveal an **'immediate threat to patient safety'**, be the most effective way to deal with the case.

18.80 The 1997 Screeners' Handbook described a change in practice that was said to have been initiated following the 1996 PSI Report. If a case was **'deferred'**, by advising the complainant to pursue it through local NHS complaints procedures, the medical screener was now to set a date for review of the case. If nothing more had been heard of the case by that date, GMC staff were to write to the complainant and to attempt to establish whether local complaints procedures had been completed and, if so, with what result. On receipt of the reply, a decision would be made whether to take the case forward under GMC procedures or, if the lay screener agreed, to close the case. If the complainant did not reply, efforts were to be made to persuade him/her to provide further evidence, failing which the case would be closed. The purpose of this change was to ensure there was a positive decision to close a case, rather than it just being left in limbo with no attempt to follow it up after it had been referred back to the complainant.

18.81 Mr Townsend described the change of practice and the reasons behind it. He said that there was an appreciation within the GMC that the way its procedures had worked previously had made them seem **'more like a complaints procedure than a public interest protection procedure'**. He had left the Conduct Section in 1998 and was unable to say what the impact of the new practice had been. At some point shortly afterwards, the new practice of setting a review date and following up complaints appears to have fallen into disuse. This may have been in 1999 when, as I shall explain, a decision was taken that cases of this type should no longer be referred to the medical screener save in certain limited circumstances.

Guidance to the Public

18.82 In November 1997, the GMC issued 'A Problem With Your Doctor?', a leaflet designed to inform the public about its procedures. Under the heading 'What to do if you have a problem with your doctor', the leaflet explained, in simple terms, the procedures for making a complaint about NHS services locally. It went on to say:

> **'However, you can complain to us even if you don't complain to your health authority or GP first. Please contact us if you would like more information about our complaints procedures, or if you want to discuss a particular problem in confidence. Our staff are experienced in dealing with complaints and will give you unbiased advice.'**

This advice (which is reproduced in the current version of the same publication) seems surprising since GMC policy continued to be that complaints about NHS treatment should be referred back to be pursued through local complaints procedures unless there was an immediate threat to patient safety. Mr Scott told the Inquiry that the leaflet was intended to be helpful but had the unintended effect of giving individuals the impression that the GMC would look at 'almost any problem' with a doctor, no matter what it was. He said that the leaflet resulted from 'a genuine lack of clarity within the organisation about how to position itself in relation to other systems and in particular the NHS complaints system'.

A Further Change in Practice

18.83 In March 1999, there was another change in practice, as a result of advice given by Professor Allen and her colleagues. They suggested that the workload of the medical screeners (which was very heavy in the mid-1990s) could be made lighter by reducing the number of cases referred unnecessarily to them. They therefore suggested that those cases that were then being referred by the medical screeners automatically to local NHS complaints procedures should, in the future, be dealt with by GMC staff. Such cases should be referred to a medical screener only if the doctor was thought to pose a risk to the public. This change was implemented in March 1999 and has continued ever since. As I have said, the criterion that must now be applied by GMC staff is whether there is cause to suspect that the doctor might be dangerous. In 2000, GMC staff advised complainants in 897 cases (20% of all complaints received in that year) to direct their complaints to local procedures. In 2001 (the last year for which a figure is available) complainants in 998 cases (18.7% of all complaints received) were so advised by members of the GMC staff.

18.84 It is clear that the practice operated by the GMC after 1999 perpetuated breaches of rule 6 of the 1988 Professional Conduct Rules. The practice returned, in effect, to that followed before 1993. According to Mr Scott, the GMC had realised in 1993 that the practice of allowing staff to take the decision to advise complainants to use local procedures, without first asking a screener to consider the case, must be changed. It is not clear whether it was also realised that the practice did not comply with the Rules. Possibly the members did not realise this, as they do not appear to have appreciated that, even after the change, the practice was still not compliant since the screeners were not applying the correct statutory test. In fact, it seems that the GMC collectively thought that the screeners were applying the right test (see above), but the screeners must have known that they were not. In any event, in 1999, the GMC accepted Professor Allen's suggestion to revert to the old practice. Professor Allen and her team are not to be blamed for offering that advice. They were not lawyers. They were simply seeking to help the GMC to deal with its workload. No one seems to have considered whether the new practice was compliant with the Rules.

Complaints about Private Treatment

18.85 In October or November 2002, the practice of advising complainants to direct their complaints initially to local complaints procedures was extended to include complaints about private treatment. This meant that patients who claimed to have received substandard treatment in private hospitals, clinics and practices or from individual private doctors were from that time advised by the GMC (in the absence of any reason to suspect that the doctor in question was an immediate danger to patients) to direct their complaints to the complaints procedures of those organisations or doctors. The Inquiry has heard no evidence about private complaints procedures. However, it seems to me that the quality and effectiveness of those procedures is likely to be extremely variable. Some of the larger providers of private health care may have well-developed complaints procedures. Other providers may not. Some complaints procedures may lack independence, particularly if the doctor practises alone or within a small organisation. It is true that, since its establishment in 2002, the NCSC (now part of the Healthcare Commission) has had responsibility for monitoring and regulating private health care, including complaints procedures. If a complainant experiences problems with the complaints procedure of a private organisation or doctor, s/he can report the matter to the Healthcare Commission. He or she could also return to the GMC. However, the onus is once again on the patient to initiate such action and to persevere if at first s/he does not succeed. Otherwise, his/her complaint will be lost to the regulatory system altogether.

Subsequent Developments

18.86 As I have said, it appears that the practice of following up the progress of complaints which had been referred back to local complaints procedures was discontinued at some point, probably in March 1999. There was no mention in the November 2002 or the April 2003 editions of the FTP Casework Manual of any review or follow-up procedure. When he gave evidence to the Inquiry in December 2003, Mr Marshall said that the only follow-up would be if the GMC were to receive a further complaint about the doctor. In that event, the original complaint would be retrieved and the new complaint considered in the light of it. However, as I shall explain, many of the doctors who have been the subject of complaints which have been closed by the GMC staff were never identified by the GMC. That being the case, there would be no possibility of complaints against them being reactivated if a later complaint about the same doctor were to be received.

Evidence about the Policy from Members and Staff at the General Medical Council

18.87 Dr Korlipara said that, in his view, it was 'only right' (save in a case where a GP was considered dangerous) that local complaints procedures should be completed before the GMC took a decision whether to act. PCTs could use their knowledge of the doctor to put the complaint in context. If necessary, the patient could be protected by immediate GMC action. Where that was not necessary, the GMC would be assisted by not having to 'go through the procedures locally'. By this, I think that Dr Korlipara meant that the GMC would not have to undertake local investigations. If the case were referred back to the GMC, it could speedily arrive at a decision (on the basis of any investigation which had been

carried out locally) as to whether there were issues of SPM which required further action. Dr Korlipara recognised that the NHS complaints procedure might be long-drawn-out but, nevertheless, felt that it was 'far more commonsensical and fair' that complaints should, wherever possible, be investigated and remedied locally. He said that the GMC should investigate only those complaints which were of such gravity that patient protection was seriously compromised or there was imminent danger to patients. If there was delay, Dr Korlipara said it was for 'some other agencies' (I take that to mean the bodies dealing with complaints) to expedite their processes so that patients did not suffer.

18.88 Dr Korlipara agreed that the system put a burden on patients. He accepted that, if a complaint were to be directed back to a local complaints procedure, it would be preferable from the patient's point of view if the GMC were to make direct contact with the local PCT, NHS trust or other complaints handling body, rather than leaving it to the complainant to do so. He did not know whether the GMC had ever considered doing this.

18.89 Other witnesses also supported the need for local investigation of complaints. For example, Mr Howes spoke of the complexity of some complaints reaching the GMC; they involved not only criticism of the treatment provided by a doctor, which was a matter for the GMC, but also such problems as hospital waiting lists and complaints about the conduct of nurses and other healthcare professionals. His preference was for a system where all complaints relating to treatment were handled speedily and well at a local level and where relevant concerns arising from those complaints were reported to the GMC.

18.90 Sir Graeme Catto thought that most complaints about clinical treatment could be more effectively and conveniently investigated locally but was concerned to ensure that the GMC was kept informed and was given the opportunity to provide any relevant information it might have. He was also anxious to preserve the existing position whereby members of the public were advised that they could bring any complaint or concern directly to the GMC if they preferred to do so.

18.91 By the time Mr Scott gave evidence, the GMC was aware of the Inquiry's concerns about the practice of referring cases back to local complaints procedures. He said that the GMC was 'considering whether instead of sending it (*i.e. a complaint*) back with a suggestion that they (*i.e. complainants*) take it elsewhere that we might do that job on their behalf, subject, of course, to their agreement that we should do so'. After the Inquiry hearings, the GMC announced that, from May 2004, it would discuss at an early stage certain complaints (broadly speaking, those where the way forward was not clear) with the doctor's employer or PCO. If, following that discussion, the GMC decided not to proceed with the complaint itself, but considered that it should be dealt with locally, it would (provided the complainant agreed) refer the case direct to the doctor's employer or PCO.

18.92 It is not known how this initiative has worked in practice. However, if it were to result in cases being directly referred by the GMC to local complaints procedures, rather than the onus being placed on complainants to do this, this should at least remove the potential for complaints to be lost between the GMC and the local complaints body. That would be a considerable advance. However, it is likely that certain problems would still persist. First, if the complaint were referred into local patient complaints procedures, the onus would still remain on the complainant to pursue it to a conclusion. Second, patient complaints

procedures – with their emphasis on patient satisfaction – are not, it seems to me, a suitable means of dealing with allegations which have a bearing on a doctor's ability to treat patients safely. They are unlikely to result in a prompt and thorough investigation of the circumstances of the case. Third, it still does not appear that any provision exists for follow-up by the GMC once a complaint has been referred to a local complaints body. It seems to me that the GMC should have a mechanism by which it can be satisfied that complaints which it has passed to other bodies for investigation or other action are being properly and expeditiously dealt with. This is particularly important in relation to complaints about treatment in the private sector.

18.93 In July 2004, a significant change was made to the second stage of the NHS complaints procedures. Instead of there being a possibility of the complaint proceeding to an IRP, a complainant dissatisfied with the outcome of the first stage of the procedure can now refer the case to the Healthcare Commission. That body will consider the case and may, if it considers it appropriate, carry out its own investigation before reaching its conclusions. In some cases, there will be oral hearing. It is anticipated that there will also be changes to the first stage of the NHS complaints procedures insofar as they relate to GPs. The reference of complaints to an independent body with investigative powers at the second stage ought to improve NHS complaints handling. As the GMC will have a working relationship with the Healthcare Commission, it should, in the future, be easier for the GMC to keep a close watch on the progress of complaints going through local procedures.

18.94 I shall refer further to the GMC's intentions in relation to holding early discussions with doctors' employers and PCOs later in this Chapter.

Specific Cases

A Complaint about Shipman: Mr J

18.95 In Chapter 6, I described the way in which a complaint against Shipman, made in August 1985, about his treatment of a patient, Mr J, who had recently died, was handled by the MSC of the FPC. It was rejected without an oral hearing. In fact, a letter of complaint was also sent to the GMC at about the same time as the complaint was lodged with the FPC.

18.96 The letter, written by Mr Steven Rawlinson, Mr J's closest friend, on behalf of Mr J's mother, complained about Shipman's clinical treatment of Mr J and alleged that Shipman had breached Mr J's medical confidentiality by speaking about his condition to Mr and Mrs G, who were also patients of Shipman. It was a detailed letter, covering four pages of typescript, and closed with the words **'I await the outcome of your investigation'**. I mention that because it demonstrates what some members of the public expected (and probably still expect) of the GMC, namely that it will investigate their complaint. After a reminder from Mr Rawlinson, a member of the GMC staff replied, advising that the complaint should be pursued through local procedures. The letter did not advise Mr Rawlinson to contact the GMC again if he was dissatisfied with the outcome of the local procedures, although it did say that it was open to him to write again to the GMC on completion of the NHS procedures. In fact, Mr Rawlinson and Mrs J had already initiated a complaint locally.

18.97 The MSC did not have jurisdiction to deal with the allegation of breach of confidentiality, as such a matter was not covered by GPs' terms of service. Only the GMC could deal with that allegation. This was recognised by the GMC staff and the letter to Mr Rawlinson promised a further communication about that part of his complaint. The member of staff also wrote an internal memorandum suggesting that the issue of confidentiality should be referred to the President, who was at that time acting as medical screener. However, she drew attention to the fact that it might be difficult for Mr Rawlinson to produce evidence of the breach of confidence as he had said that Mr and Mrs G might be unwilling to give evidence against Shipman. The outcome was that a letter went to Mr Rawlinson advising him that it would be possible for the GMC to take proceedings against Shipman only if both he and Mr and Mrs G were to provide statutory declarations supporting the complaint. Mr Rawlinson now has no recollection of receiving that letter but I think it likely that he did and that he and Mrs J realised that there would be no prospect of persuading Mr and Mrs G to provide a statutory declaration supporting the complaint. That complaint went no further.

18.98 The GMC's handling of the complaint about clinical treatment was typical of the response that the GMC would have given to such a complaint over a very long period of time. Indeed, the approach would not have been markedly different if the complaint had been made in 2003. The complaint was one which, on investigation, might or might not have revealed conduct amounting to SPM. The GMC did not investigate it at all but advised the use of local procedures. As I have explained in Chapter 6, it is not clear how thoroughly the complaint was investigated locally. The complainant had no power to obtain documents. The complaint covered treatment over a substantial period of time but it is not clear whether the MSC waived the time limit and considered events that occurred more than eight weeks before the date of the complaint. I think it probable it did not. The complaint was rejected without an oral hearing. The basis of the decision is not clear, save that it appears that the MSC did not think that Shipman's treatment had contributed to Mr J's death. I cannot say what would have been the outcome if the case had been properly investigated and had not been affected by problems of time limits. In short, the GMC referred the case back into a procedure that was far from satisfactory. Shipman's treatment of Mr J may have been seriously substandard and such as to render him guilty of SPM. We will never know.

Other Case Files

18.99 The Inquiry obtained the papers relating to the last five cases which had been closed by GMC staff prior to 30th September 2003, where complainants had been advised to refer their complaints to NHS complaints procedures. The Inquiry also obtained the papers in the last five cases prior to 30th September 2003 where complainants had been advised to refer their complaints to private complaints procedures. Three of the latter cases caused me some concern. I shall discuss them later in this Chapter: see paragraphs 18.181–18.184 and 18.213–18.227. The other complaints raised issues which appeared appropriate for referral to local procedures. Whether or not that referral took place, however, was left entirely in the hands of the complainant in each case. The GMC had no means of checking that this had been done.

Comment

18.100 I regret to say that I am critical of the GMC's policy towards complaints about medical treatment made by private individuals. As I have explained, the practice by which such complaints were handled did not comply with rule 6 of the 1988 Professional Conduct Rules. But it is not the fact that the practice was unlawful which concerns me most. What most concerns me is that the policy of the GMC in respect of complaints from private individuals had the effect of virtually forcing complainants to go through local complaints procedures unless the complaint appeared to be so serious that the GMC considered that doctor presented an immediate risk to patients. The GMC has been turning away many cases without considering whether the conduct alleged might amount to SPM. It has been requiring complainants to go through a local process which requires determination and persistence and which, moreover, is not likely to result in a thorough investigation of the facts.

18.101 The GMC's claim that it is better for local procedures to be used because local NHS organisations can provide a better opportunity for investigation flies in the face of reality. The complaints procedures on which the GMC has been content to rely have suffered from a number of defects. Those defects have been well known to members and staff of the GMC for decades. Mr Howes said in evidence:

> **'I do not know anybody who thinks highly of any of the past NHS systems or existing NHS systems for dealing with complaints and concerns.'**

18.102 It must have been clear that the inevitable result of the defects in the system was that many cases where the fitness to practise of a doctor was in doubt would not return to the GMC. The implications for patient safety should have been obvious. Until relatively recently, the PCOs had no power to restrict a doctor's practice, the powers of the NHS Tribunal were rarely exercised and hospital disciplinary systems were known to be ineffective. The fact that cases of potential SPM were not getting to the GMC meant that doctors who were unfit to practise were continuing to treat patients. To the Inquiry's knowledge, the position was particularly difficult in the field of primary care. I have already mentioned the limited role of PCOs in the handling of complaints against GPs. Often, they were not aware of a complaint and, even if they were, they had no official investigatory role. Only in a small minority of cases was there any possibility of a case being referred back to the GMC. Those were cases in which an independent review took place, the report was seriously critical of the doctor and the PCO was sufficiently concerned to refer the case onwards to the GMC rather than attempting remedial measures of its own. Also, there was a small number of incidents which, for some reason or another, came to a PCO's attention and were directly investigated by it. Such an investigation might result in a referral to the GMC. But the great majority of complaints would follow the 'usual procedures' and would never be investigated at all. I shall not comment further on the position in respect of hospital cases, as the Inquiry has not examined them in detail. I accept of course that the GMC has no control over the quality of NHS complaints procedures or of those in the private sector. Yet, notwithstanding its knowledge that the procedures were defective and that it had no power to do anything about that, the GMC persisted, over a period of many years, in requiring complainants to 'exhaust' their local remedies.

18.103 In my view, the GMC policy that I have described amounted to a failure of its duty. The GMC accepted and dealt with the most serious cases but consistently failed complainants who reported matters which might well have involved SPM, but which did not, in the opinion of the GMC, give rise to an obvious risk to patient safety. This policy did not honour the GMC's primary duty to protect patients. It is clear from the evidence that a significant factor underlying the policy was the desire to be 'fair to doctors'; in practice, the effect was to protect doctors from the investigation of complaints and from the possibility of disciplinary action. The policy also enabled the GMC to avoid handling a substantial number of cases which it would otherwise have had to deal with. And, in addition to all that, the policy resulted in a practice that was manifestly in breach of rule 6 and therefore unlawful.

18.104 I can well understand the GMC's view that many complaints about doctors are, in principle, best investigated locally. Indeed, if the local resources were satisfactory, if the procedures were reasonably speedy and did not rely on the complainant to pursue the complaint and if there were proper, reliable mechanisms for referring cases to the GMC when appropriate, I would agree that a system which provided for initial investigation locally would be ideal. However, as the GMC recognises, local resources are not satisfactory, procedures are not reasonably speedy and the onus is always on the complainant to pursue the complaint. Nonetheless, the GMC has maintained its policy over many years. Part of the problem has undoubtedly been that the GMC has never had an adequate in-house investigating facility. As I explained in Chapter 16 and as I shall explain further below, in the past, the GMC has only ever fully investigated a case in preparation for a disciplinary hearing. But another aspect of the problem has been the GMC's uncertainty and ambivalence about its role and about its position in relation to NHS complaints procedures. It seems to me that the GMC does not really want to receive a wide range of 'raw' complaints; it prefers to receive reports from other organisations which have already gathered and evaluated the evidence. Then, it is easy for the GMC to decide whether any FTP procedures should follow and to carry out such further investigation as it considers necessary before the hearing. But, as we have seen, the GMC still holds itself out to the public at large as the primary recipient of all complaints about doctors.

18.105 In my view, the GMC really will have to make its mind up where it stands. One option is that it should receive only those complaints which other bodies (whether NHS or private) think should be referred – either in an uninvestigated state because they are obviously very serious or after investigation because they appear to the investigating body to raise a question about the doctor's fitness to practise. The other possibility is that it carries on as now, opening its doors to all comers. If it decides to do that, it really must give proper consideration to every complaint. It must investigate it to the extent necessary to see whether action should be taken. It is not acceptable, in my view, for the GMC to seek to keep a foot in both camps: offering to receive all complaints and then selecting for investigation only those which raise the most obvious concerns about the safety of patients.

18.106 The GMC has suggested that the problem might be resolved by the creation of a 'single portal', which, as I understand the suggestion, would provide advice to potential complainants about where to direct their complaints. It does appear that quite a number

of complaints are directed to the wrong place or are received by bodies that are not complaints handling bodies at all. For example, Professor Alastair Scotland, Chief Executive and Medical Director of the NCAA, said that it receives quite a number. Members of staff always seek to help a complainant to identify the right destination for his/her complaint or concern and sometimes contact the appropriate body to facilitate the complaint's progress. There are real attractions in this suggestion and I shall consider it in greater detail later in this Report. However, even if such a facility were to be introduced, it would still be necessary for the GMC to clarify its own role, not only in its own mind but also in the minds of the public.

Investigating the Circumstances of a Complaint

Complaints from Public Bodies and Private Individuals

18.107 The extent and quality of evidence available when a complaint comes to the GMC from a public body is, in general, very different from that which is provided by a private individual. A complaint from a private individual might consist of a letter only. The letter might not be very full or articulate. It might not deal with all the relevant issues. It might not contain details of available witnesses or of other supporting evidence. By contrast, a complaint from a public body is likely to have been preceded by some sort of investigation or inquiry. The letter of complaint will usually set out the issues clearly. It will often be supported by a body of evidence. It may be accompanied by a report of an IRP (or, under the new arrangements for the second stage of the complaints procedures, a Healthcare Commission panel) which has made findings against the doctor. The quality and extent of local investigations may be very variable. Nevertheless, it has hitherto been the practice of the GMC to rely on the evidence collected by local bodies without – certainly at the early stages of its procedures – undertaking any additional investigations of its own.

18.108 A private individual who makes a complaint about a doctor to the GMC will usually lack the necessary resources to carry out his/her own investigation. He or she will therefore expect that the GMC will conduct a thorough investigation of the complaint and that only when all the relevant information is known will the GMC make an informed decision as to what, if any, action is required in respect of the doctor. In other words, there is an expectation that the GMC will fulfil the function usually performed by an organisation which is designed and equipped to handle and adjudicate upon complaints from members of the public. The reality, however, is rather different.

The Meaning of 'Investigation'

18.109 It is important to define what I mean by the term 'investigation'. By 'investigation', I mean the gathering of information and evidence relating to the circumstances giving rise to a complaint. Such an investigation might involve:

- asking questions of the complainant and obtaining a statement from him/her
- discovering from the complainant the identity of any potential witnesses (e.g. friends and family of the complainant with knowledge of the circumstances), and obtaining statements from them

- obtaining any relevant medical records, test results and other documents
- obtaining documentary evidence about other investigations such as transcripts of inquests and (in the past) reports of IRP hearings
- obtaining a statement from the doctor complained of and from any witness of fact whom s/he may put forward
- obtaining evidence from an expert in the relevant specialty
- obtaining the comments of the complainant (and possibly other witnesses) on the account given by the doctor and his/her witnesses and vice versa
- initiating other enquiries, e.g. checking facts which have been asserted by the complainant or the doctor with third parties and/or with existing documentation.

18.110 Investigation is a task which requires considerable expertise, particularly where the matter to be investigated involves complex medical procedures or issues. Investigation can also require a degree of determination, inquisitiveness and perseverance in order to ascertain what happened or, where there is a conflict of evidence, in order to identify precisely where the differences between the accounts given by the various witnesses lie.

The Report of the Merrison Committee

18.111 The Report of the Merrison Committee, to which I have already referred, was published in 1975. The Report discussed the issue of investigation. It pointed out that, in the early period of the GMC's history, there were only three circumstances in which the GMC would take action in respect of reports that a doctor had been guilty of SPM. The first was when it received information about the alleged misconduct from a public body. The second was when it received information about the alleged misconduct from another source and when that information included all the evidence required for the GMC's purposes. The third circumstance was when there was a complainant (usually a private individual) who was prepared to assemble the evidence him/herself and to present it at a hearing of the Disciplinary Committee (the predecessor of the PCC). The Merrison Report also pointed out that, during the previous ten to fifteen years, the GMC had taken the view that, if it continued to limit its activity as previously, some types of professional misconduct that gave rise to public criticism would not be dealt with. It had therefore started to collect evidence itself and to prosecute in certain types of case. The Merrison Committee expressed the view that this action was **'entirely justified'** and should be continued **'in the interest both of the public and of the profession'**.

18.112 The Merrison Report therefore recommended that the GMC should set up a small unit, possibly under the supervision of a medically qualified official, to investigate allegations against doctors. This was because the Merrison Committee considered it important that the GMC should be able to **'... assess as quickly as possible which complaints are substantial so that action, including the dismissal of unfounded allegations, can be taken without undue delay'**. The Merrison Committee recommended that the investigation unit should operate under the personal direction of the President, who would supervise the early stages of the FTP procedures and would act as the screener. The

investigation unit would be used principally for the investigation of complaints from private individuals. Its role would be to establish **'in a preliminary and neutral way'** the facts of the case. Because members of the Merrison Committee considered that points of difficulty could often be better elucidated by a personal interview than by an exchange of letters, they suggested that discussions should take place between a representative of the investigation unit and the doctor involved and between the representative and other parties to the complaint. At the end of the investigation, the investigation unit should submit a report to the President, who would then take the decision whether the case should be either dismissed or taken further.

18.113 These recommendations, which seem to me to be eminently sensible, were never implemented. In 1988, Mrs Robinson expressed surprise that the GMC did not have its own investigation unit, and contrasted the position of the GMC with that of the Ombudsman, who had a permanent staff of experienced investigators. In 1988, as was the case until very recently, private firms of solicitors retained by the GMC would investigate and prepare cases for hearing by the PCC. The solicitors employed trained investigators, including former police officers. The Inquiry has been told, and I have no reason to doubt, that the GMC's solicitors have, in the past, carried out some extensive and very thorough investigations in preparation for PCC hearings. The cases arising out of the Bristol Royal Infirmary paediatric cardiology deaths were cited as examples of this. However, it was rare for the GMC's solicitors to be involved in gathering information about the circumstances of a complaint at a time before the complaint had been referred by the PPC for hearing by the PCC.

18.114 As the Merrison Committee recognised, the need for investigation by the GMC arose primarily in connection with complaints made by private individuals. As I have said, most complaints by private individuals about NHS treatment would be referred back to local complaints procedures for investigation. However, that would still leave complaints about private treatment (until recently), together with complaints which fell outside the time limits for local complaints procedures or those which for other reasons could not be dealt with by means of local complaints procedures.

The Lack of Investigative Powers

18.115 Until 2000, the GMC had no power to compel the production of documents or the provision of information until a case had been referred by the PPC to the PCC. Mr Howes, who was employed by the GMC between 1977 and 2002, did not think that anyone had ever put forward a proposal that the GMC should be given power to act earlier. I can only assume that that was because it was never really contemplated that investigations (other than seeking the doctor's response to the complaint made against him/her) would be carried out at a stage in the proceedings earlier than the time of referral to the PCC.

18.116 The 1994 Training Manual compiled by Mr Howes set out the position at that time:

> **'So far as sufficiency of the evidence is concerned, this is largely a matter of common sense, rather than law. For example, if a complaint alleges that a doctor has breached professional confidence in a letter sent to the complainant's employer, the Council will need to see a copy**

of that letter, so as to be reassured that the doctor did in fact write such a letter, and that it did indeed contain confidential information concerning the medical history, condition and/or treatment of the person concerned. We will also need information from the complainant about the circumstances which led to the letter being sent. Therefore, if the complainant is not able to produce a copy of the letter in question, the view taken by the preliminary screener will normally be that the evidence is insufficient to justify disciplinary proceedings against the doctor, regardless of the gravity of the allegation. The onus to produce evidence is almost entirely on the complainant, and not on the GMC, because the GMC does not have much by way of investigative powers at the preliminary stage of the procedures; its powers of subpoena are confined to cases being heard by the PCC or Health Committee. Thus for example, in the hypothetical breach of confidence case mentioned above, the Council would have no means of obtaining a copy of the letter giving rise to the complaint, nor does the Council have access to a doctor's medical records.'

18.117 In that passage, there appears to be a fundamental confusion between the GMC's lack of **'investigative powers'** during the preliminary stages and its ability to investigate at all. Mr Scott agreed that such confusion existed in the minds of some GMC staff and members. It is true, as I have said, that the GMC had no power to compel disclosure of documents or the provision of information until a decision had been taken to refer a complaint to the PCC. But, regardless of its lack of such a power, there would have been nothing, in the example given in the passage above, to prevent a member of the GMC's staff from asking the complainant's employer for a copy of the letter. It might have been provided voluntarily. Mr Howes said that the GMC would have expected the complainant to get a copy of the letter from his/her employer. If s/he could not produce the letter, he said that 'one would wonder why'. When asked why the GMC could not itself have made that sort of enquiry, he replied:

'Well, the Council could, but the Council, if you like, is not there to make out the complainant's case. The Council is supposed to be impartial and, therefore, certainly at that time, the thinking was that we should be impartial. There was no part of our job to assist a doctor with his defence against a charge and it was no part of our job to go overboard and make the case out for the complainant. The complainant had to make out the *prima facie* (*case*), we would then if we said there was a *prima facie* case take it on board and do the rest and we would pay for the costs of the case ... in front of the Disciplinary Committee, etc. We were prepared to take on a case once the complainant if you like had done their bit and made out a case.'

18.118 At a later stage, Mr Howes said:

'... we did not really regard it as our job in those days to help the complainant any more than it was our job to help the doctor with his

defence. If the complainant wished to bring a complaint against the doctor then the law allowed them to do that with certain limits, and it was our job to adjudicate on that complaint and I think we concentrated on that aspect. That is not the way the GMC looks at these matters now, but I think that is the way it was looked at then.'

18.119 There were, however, circumstances in which the GMC was prepared to initiate investigations at an early stage, despite its lack of power and the usual expectation that the complainant would provide the evidence. This is illustrated in the next paragraph of the 1994 Training Manual:

> **'In a very small number of cases, however, the medical preliminary screener may consider, on the advice of the office, that the matters alleged are so serious that a thorough informal investigation should be carried out locally by the Council's solicitors, who will then attempt to investigate the case and take statements, in so far as potential witnesses are prepared to cooperate. However, because the resources of the Council's Solicitors are limited, it is not possible to investigate many cases of potential serious professional misconduct in this way; screeners usually limit them to cases of considerable public interest.'**

18.120 If investigations could be undertaken on some occasions, then the absence of powers was plainly not considered to be a complete bar. However, it is plain that a decision had been taken to restrict investigations to serious cases, in particular those with a high public profile. When asked for examples of cases when an investigation might be mounted, Mr Howes cited complaints of irresponsible prescribing to addicts or multiple allegations of indecency against a doctor.

18.121 Mr Townsend agreed that there was probably some confusion of thought between the absence of a power to compel people to co-operate and the inability to investigate at all. He felt that the fact that there was a real difficulty if people did not co-operate tended to make staff disinclined to attempt to investigate. The view that it was the complainant's responsibility to assemble the evidence in support of his/her complaint was another factor. He agreed that, in the 'large majority of cases', the onus was on the individual complainant to provide the evidence necessary to demonstrate a *prima facie* case of SPM. That individual would not be interviewed by GMC staff nor, save in exceptional circumstances, would other potential witnesses be approached or interviewed. Instead, the complainant him/herself would be encouraged to obtain statements from any potential witnesses.

18.122 Some witnesses at the Inquiry mentioned the fact that the Rules did not confer on medical screeners in conduct cases any specific power to investigate. The PPC, together with screeners dealing with cases where the health of the doctor was in issue (health screeners) and medical screeners dealing with performance cases, were given a specific power. It was suggested that this absence of a specific power might have discouraged staff and screeners from undertaking investigations. I do not see how this can be the case. It is clear that, if a case was considered sufficiently serious and/or high profile, investigations were undertaken. Screeners did on occasion cause further information (e.g. expert opinion) to be obtained. The absence of a specific power did not prevent them

from doing this. Moreover, I was not told that there had ever been any attempt to seek such a power. It seems to me that the lack of investigation was attributable mainly to a feeling that it was for the complainant (not the GMC) to substantiate his/her complaint. The absence of any power to compel production of documents and information cannot have helped. However, that could no doubt have been rectified had it been considered necessary or desirable to do so.

The Work of the Policy Studies Institute

18.123 The 1996 PSI Report drew attention to the lack of investigation. It suggested that the GMC should consider carrying out some investigation before a case went to a medical screener or, if not then, after screening and pending consideration by the PPC. At that time, it was not the practice even to seek the response of the doctor to a complaint made against him/her before the complaint was screened. The Report suggested that, at a minimum, this should be done where there appeared to be the possibility of a *prima facie* case of SPM. That change was instituted shortly afterwards. The Report also raised the possibility of seeking further evidence, over and above the response of the doctor. Some years later, in about 2000, the GMC extended its 'investigatory' procedures by inviting the complainant to comment upon the doctor's response to, or explanation of, the matters alleged. However, it did not and never has routinely undertaken any other form of evidence gathering such as the taking of witness statements during the preliminary stages.

18.124 As the 1994 Training Manual had made clear, when a private individual made a complaint to the GMC, s/he bore responsibility for gathering the necessary evidence in support of the allegation. The 1996 PSI Report showed that, in a significant proportion (22%) of cases in which the GMC took no action, the reason for lack of action was that the GMC had requested further evidence from the complainant but had received no response. If no response was received from a complainant, there was usually no follow-up request. Professor Allen told the Inquiry that she thought that complainants might have found such requests for further evidence intimidating. She and her colleagues were concerned at the onus being put on complainants and at the fact that complaints involving SPM might have been lost. It was for that reason that the PSI team had recommended that the GMC should consider carrying out investigations itself.

18.125 The PSI team had other concerns about the lack of investigation by the GMC of complaints made by private individuals. The 1996 PSI Report showed that by far the single most important factor in determining whether or not a complaint was acted upon by the GMC was whether the complaint came from a public body or from a private individual. In the year to August 1994, 66% of doctors referred to the PPC, and 72% of doctors who were referred by the PPC to the PCC, had been referred by public bodies. The 2000 PSI Report produced similar results. Complaints made by private individuals against doctors were referred by medical screeners to the PPC relatively rarely: 5% of such complaints were referred in 1997, 6% in 1998 and 13% in 1999.

18.126 Professor Allen and her colleagues recognised that the disparities in outcome between complaints coming from private individuals and those from public bodies could reflect the fact that complaints made by public bodies were for some reason intrinsically more

serious than those made by private individuals. If that were so, it would not be surprising that a greater proportion progressed further than the screening stage. However, they urged caution in assuming that this was the reason for the different outcomes. They believed that the differences in outcome might instead be caused by differences in the quantity and quality of evidence provided by public bodies, when compared with that provided by private individuals. If this were correct, the effect of the GMC's failure to investigate complaints would have been that some complaints from private individuals which should have been the subject of disciplinary action by the GMC were being rejected because of lack of evidence.

18.127 Mr Townsend agreed that the disparities in outcome between complaints made by public bodies and those made by private individuals were, in part, accounted for by the fact that a public body would have gathered more evidence than would a private individual. Moreover, that evidence would have been sifted. A judgement would have been taken on the probity of the evidence. Another factor was, he thought, the series of hurdles which a private individual had to overcome. These included (until November 2002) the requirement for a statutory declaration to be provided. He felt that these hurdles might have discouraged an individual from taking his/her complaint forward.

18.128 It seems to me entirely understandable that virtually all complaints received from a public body should be found by the GMC to require some sort of disciplinary action. The allegations would already have been investigated and a judgement made that the allegation was serious enough to refer to the GMC. However, it is a matter of concern that the GMC has not been prepared to undertake a **'preliminary and neutral'** investigation of complaints made by private individuals. I fear that many valid complaints will have been closed because of the failure to investigate. I recognise that to undertake such investigations would have been a costly exercise for the GMC. However, I have the clear impression that cost was not the only reason why such investigations were not undertaken. The impression I received was that complaints from individuals were suspected of being, in some way, unreliable, at least unless and until the complainant could produce sufficient evidence to amount to a *prima facie* case of SPM, backed – until November 2002 – by a statutory declaration. Also, there was resistance to any action which might be seen as 'assisting complainants' and, therefore, as 'unfair to doctors'.

Subsequent Developments

18.129 The 1997 Screeners' Handbook referred to the fact that, in more complicated cases, the GMC's solicitors might be asked to obtain evidence before a case was screened. They could interview witnesses and, although they had no power to compel the production of evidence at that stage, it was said that they were **'frequently able to secure the co-operation of individuals and authorities through personal contact'**. It does not appear that this was often done. The option of obtaining expert advice before screening was also discussed.

18.130 The version of the FTP Casework Manual published in April 2003 emphasised that the amount of evidence required by the screeners was **'minimal'**. They simply needed to have enough information to understand what the allegation was. Caseworkers were

enjoined to have this **'very firmly in mind'** when deciding what information should be collected before screening. The **'menu of evidence-collection options'** open to caseworkers at this stage included the following:

- disclosing the complaint to the doctor and inviting comments. (This practice of disclosing a complaint to a doctor before screening was, as I have said, introduced in response to the recommendation made in the 1996 PSI Report.)
- disclosing the doctor's comments to the complainant, giving the opportunity for further comment. (This practice was introduced in July 2000 in anticipation of the coming into force of the Human Rights Act 1998. Prior to that, neither the medical screener nor the PPC had had any comments from the complainant in relation to the doctor's response to the complaint.)
- if the complainant provided further comments, disclosing those comments to the doctor for his/her further observations
- obtaining medical records in an appropriate case
- making enquiries with the doctor's employers or PCO. (I shall deal with this option later in this Chapter.)
- seeking evidence or statements from potential witnesses by correspondence or through the GMC's solicitors. (This was said to be necessary in some cases to clarify the nature of the allegations against the doctor. However, staff were cautioned against holding up a screener's decision by **'chasing evidence required only at a later stage'**.)
- seeking an expert medical opinion in cases involving issues which appeared **'very complex and unusual'** and where there was no form of medical opinion already included with the complaint.

18.131 It is clear from the contents of the April 2003 FTP Casework Manual that the aim at this stage of the GMC procedures was not to conduct a thorough investigation of the circumstances of the complaint. Rather it was to ensure that the medical screener had the **'minimal'** evidence required for his/her purposes, i.e. for the purpose of deciding whether the complaint raised a question of SPM.

18.132 There were a number of problems with this approach. First, that evidence which was regarded by a member of the GMC staff as **'minimal'** but adequate might be regarded by a medical screener as insufficient to found a *prima facie* case of SPM. The case might, therefore, fail at the screening hurdle when, had more evidence been available, this would not have happened. Second, in a case involving allegations of substandard clinical practice, it is essential to establish the factual basis first, in order that any expert opinion obtained (and that any opinion formed by the medical screener) should not be based upon a misunderstanding of the facts. Third, in the absence of the full facts, a screener might be tempted to make assumptions about what had occurred. Fourth, the complaint, as initially recounted by the individual concerned, might not have been immediately recognisable as serious; this might have become evident only if the complaint had been properly investigated.

18.133 In December 2003, Mr Scott told the Inquiry that, in general, there was still limited evidence gathering prior to a screening decision. He observed that the existing procedures appeared a 'paradox'. A complaint was screened, referred to the PPC, referred on to the PCC, charges were formulated, and only at that point did the GMC set about finding evidence to support the charges. He referred to this process as 'putting the cart before the horse'. He went on to say:

> **'The more rational way may be to gather such evidence as appears to you to be relevant and then you formulate the charges accordingly. That has been an impediment I think to progress throughout the 1990s, which will not be fully resolved until new procedures come into play ... .'**

18.134 That reference to the new procedures, and the changes that would come about as a result, was echoed by other witnesses from the GMC. I shall consider the new procedures, and their implication for investigation of complaints, in Chapter 25. However, I cannot understand why, having recognised the deficiencies in their existing procedures, the GMC felt it necessary to wait for the introduction of the new procedures before instituting proper investigative procedures.

18.135 In 2003, the GMC began to recruit a team of solicitors, paralegals and support staff. Mr Scott said that he had expected that, when complete, the team would number about 20 people in all. Mr Scott did not suggest, at the time he gave evidence in December 2003, that the job of the team was to gather evidence about complaints in the early stages. Rather, the team appeared to be assuming the role previously carried out by private firms of solicitors who had been retained by the GMC to prepare cases for hearing by the PCC and, possibly, the role of counsel who had previously presented the cases to the PCC. In 2004, the GMC has advertised with a view to recruiting investigators and I assume that these people will be used to investigate cases under the new procedures.

Statutory Declarations

18.136 For many years, the GMC Rules required complaints made by private individuals (but not those made by persons acting in a public capacity), together with statements from witnesses in support of such complaints, to be supported by statutory declarations. The purpose of this requirement was to establish the *bona fides* of the complainant and his/her witnesses. It was also intended to deter the making of malicious complaints. However, its effect, as the GMC eventually recognised, was to deter genuine ones. In general, complainants were asked to provide one or more statutory declaration immediately after a decision had been taken by the medical screener that a complaint should be taken forward. If no statutory declaration was provided, the referral to the PPC would not proceed. In the case of the complaint about Shipman in respect of Mr J, the complainant was told that both the complainant's evidence and that of the principal witnesses would have to be supported by statutory declaration. In general, the complainant was required to make the necessary arrangements and to bear the cost of providing the statutory declaration. If the complainant was able to draw up the statement him/herself, the cost of swearing it was relatively modest. If, however, the complaint was more complex and the complainant required the assistance of a solicitor to draft a

statement, the cost would be substantial enough to deter many people. The very fact of having to approach a solicitor to have a statement sworn may have been intimidating to some. In the 1996 PSI Report, Professor Allen and her colleagues recommended that the requirement for a statutory declaration should be reviewed.

18.137 It is clear from the 1994 Training Manual that the GMC staff were well aware of the financial and other burdens placed on complainants in connection with the obtaining of a statutory declaration. They sought, wherever possible, to advise and assist complainants in order to keep expense to a minimum. However, there was recognition that, in most cases, it would be necessary for complainants to approach a solicitor in order for the statutory declaration to be obtained. In later years, financial assistance was available to complainants in certain circumstances. However, they had to ask for it and many were unaware that this was possible. The witnesses agreed that the requirement for a statutory declaration had had the effect of discouraging some complainants from pursuing their complaints. Mr Howes accepted in evidence that 'many, many complainants' had not provided statutory declarations when required to do so. He said that he and other members of staff had not wanted the requirement for a statutory declaration to be an undue barrier to making a complaint but it had been part of the Rules and it was not for the staff to try to bypass the requirement. Nor, he said, did the staff have any authority to say to every single complainant that the GMC would authorise and pay for the declaration. He said:

> **'... I think we were all the time pushing at the boundaries of how we could help people and in how many cases we could perhaps find money to help them and so on. But it was a question of pushing back the boundaries, particularly as there was a strong feeling I think that on the medical side of the argument that we should not be helping complainants at all in this way.'**

18.138 He said that the GMC was 'walking the tightrope between the public interest and the professional interest'. It was there to sit in judgement on a complaint, not to help the complainant or to 'side with' the doctor. If the staff bent over backwards to make sure a complainant's case was supported, the view of the medical profession might be that the GMC was clearly siding with complainants all the time. Doctors would question how they could get a fair hearing at the GMC. He said that one had to be seen to be fair and also, from the complainant's point of view, had to be seen not to be putting an 'absolutely insurmountable barrier' in his/her way. He went on:

> **'... every time that the Procedure Rules were in front of the Council for some sort of amendment, this is the sort of issue that would be raised, is it not about time we took away our insistence that they make sworn statements and this argument would then be in front of the Council and people would stand up, some of them saying, ''I think we should continue with sworn statements,'' and others saying, ''No, this is quite wrong and it is a terrible burden on complainants and unnecessary.''**
>
> **So you would get this argument and then the latest outcome was that they should not be – this requirement should at last be taken away and**

that was relatively recently. Until then the argument had always been (*won*) **from the other angle.**

I am not saying it was always profession against lay, but I think probably the argument was very much one of ''Is this fair to the doctor?'' against ''Is this fair to the complainant?'' '

Mr Howes said that the GMC was 'in an impossible position'. He went on to say that he thought things gradually improved and that the GMC now gave much more help to complainants.

18.139 The fact that many complainants failed to provide a statutory declaration must inevitably have meant that cases of potential SPM were lost to the system. In addition, it is clear that the requirement must have created the impression, in the eyes of many complainants, that the GMC was not prepared to take the complaint seriously or to 'trouble' the doctor with it until evidence of a very high standard had been produced. In short, it gave the impression that the GMC was 'on the doctor's side'.

18.140 The requirement for a statutory declaration was eventually abolished in November 2002.

Comment

18.141 It is evident that, up to now, the GMC has done little to investigate complaints made to it unless and until those complaints have been referred by the PPC to the PCC. At that point, solicitors retained by the GMC have taken over preparation of the case for hearing. The complaint has then been subjected to investigation by someone with a degree of independence and some expertise in investigation. In a very few (usually high profile) cases, investigations have been put in train at an earlier stage. The vast majority of complaints – in particular those made by private individuals and those relating to substandard clinical practice – have been closed well before that point. They have been closed without any personal contact with the complainant and without any attempt to elucidate the complaint or to find evidence that might support or refute it. In a treatment case, medical records may have been obtained and, in a complex case, expert evidence sought. Where the facts were very uncertain, however, expert evidence might be of limited assistance unless and until the facts were clearer. It seems likely, as Professor Allen and her colleagues believed, that complaints which would have amounted to SPM have been screened out as a result of lack of investigation.

18.142 The fact is that the GMC's policy has been to refer complaints about medical treatment back for local investigation by NHS bodies, in effect relying on those bodies to do the investigation for it. Until the NHS body provided the evidence to the GMC as a package, the GMC was unlikely to act. The wisdom of pursuing this policy was obviously questionable because, as the GMC itself has recognised, the quality of local investigation was very variable and much depended on the determination of the complainant to reach a proper resolution of the issues rather than a fudging of them. There is no way of knowing how many cases that should have been dealt with by the GMC were not.

18.143 The idea that the GMC should establish an investigation unit to gather evidence about complaints at an early stage in its process is not a new one. The Merrison Committee

recommended this step almost 30 years ago. Like Mrs Robinson in 1988, I was extremely surprised in 2003 to learn that, until very recently, the GMC had had no in-house investigative expertise.

18.144 It seems to me that there are a number of reasons why the GMC has not undertaken any investigation of complaints at the pre-screening stage. Part of the explanation lies, I believe, in the history to which I referred at paragraph 18.111. In the past, a private individual who wanted to bring a complaint against a doctor bore the entire responsibility for assembling the necessary evidence and for presenting the case at a hearing. More recently, although complainants still had the right to present cases before the PCC if they chose, the more usual arrangement was for the GMC to 'take over' complaints once they had been referred to the PCC. The GMC would then be responsible for preparing the case and presenting it at the hearing; the complainant's role would be that of a witness only. However, the principle that it was for the complainant to establish the basis of the case at the outset, by providing the necessary evidence, lingered on. There does not appear to have been any real appreciation of the difficulties this caused for complainants. Nor was there any recognition of the fact that, if a complainant was unable or unwilling to take the necessary steps to assemble the evidence, this might mean that a complaint of real substance was lost to the regulatory process, with a concomitant risk to the public and to patients.

18.145 There was also the view that it was the GMC's role to act as independent arbiter, not to assist in gathering evidence to support one party to the complaint or the other. It seems to have been thought that to investigate a complaint was in some way 'anti-doctor'. In an organisation where most members are elected by the profession, a member who advocated the robust investigation of all complaints might have been unpopular with his/her constituents. I have the clear impression that some members took a view that was protective of the interests of doctors and would have opposed investigation of complaints on principle. There seems to have been a failure to recognise that an investigation of the circumstances surrounding a complaint should not be partisan. Its purpose should have been, as the Merrison Committee recognised, to enquire into the facts **'in a preliminary and neutral way'**. Moreover, the notion that it would be 'unfair' to doctors for the GMC to undertake an investigation of complaints failed to take account of the imbalance in the relationship between the complainant and the doctor about whom the complaint had been made. The former lacked the resources to investigate; the latter was generally supported by expertise and funding from his/her medical defence organisation and had ready access to expert medical opinion.

18.146 I believe that another reason for the failure to investigate has been the issue of resources. Investigation is an expensive process and if all, or most, complaints from private individuals had been subjected to a reasonable level of investigation, this would have placed a considerable burden on the medical profession. A GMC member who voted in favour of employing a team of investigators might well have lost his/her seat on the Council. There has also been a lack of investigative expertise among existing GMC staff and, indeed, an apparent lack of understanding of how an investigation should be undertaken.

18.147 Another reason is the problem that I have mentioned before, namely the lack of clarity about the GMC's role. If the GMC had made it clear that its function was to consider only serious complaints which had already been identified and investigated by others, and that it was not prepared to undertake any investigations unless there was no other body available to do so, that might have represented a perfectly reasonable position for a regulatory body to take. Such a stance would have thrown into sharper focus the patchy quality of investigations carried out by NHS organisations and the virtual absence of any local investigation of complaints about a GP. But, instead, the GMC has at all times held itself out as a willing recipient of complaints direct from members of the public. I have in mind such publications as 'A Problem With Your Doctor?' and its successor, 'Referring a doctor to the GMC – a Guide for Patients'. Although, at times, these publications made oblique references to the limited jurisdiction of the GMC, the general impression they conveyed was that the GMC would receive and investigate any complaint about a doctor and would also give advice. Many complainants to the GMC, as we have seen, have been sent away to make use of local procedures. Those members of the public who were not dealt with in that way have expected that their complaints would be properly investigated and determined. They have never been told by the GMC that it is not prepared to do this. Indeed, many individuals whose complaints have in the past been rejected by the GMC will have had no idea that the only action which the GMC took in relation to their complaint was to show it to a medical screener who screened it out. For many years, there has been a gulf between public perception of the GMC as a proactive investigator of complaints against doctors and the reality. The GMC has failed to recognise this gulf or, if it has recognised it, has failed to take any action to bridge it. Moreover, it has failed to recognise that its lack of investigation has meant that some complaints which might have amounted to SPM have failed, with potentially serious implications for patient safety.

18.148 The Inquiry has been told that, under the new FTP procedures, things will be different and complaints will be investigated properly before a decision is made whether to take them forward or to reject them. I shall discuss the GMC's assertions about the future in Chapter 25, when I examine its proposed arrangements for the new 'investigation stage'.

Communications with Doctors' Employers and Primary Care Organisations

18.149 There are three main reasons why it might be helpful for the GMC to communicate at an early stage in its processes with the employer of a doctor against whom a complaint has been made or with the PCO (now the PCT) on whose list the doctor appears. First, it would enable the GMC to discover whether the employer/PCT had any information about the doctor which might assist the GMC in assessing and dealing appropriately with the complaint which had been made to it. Second, it would alert the employer or PCT to the fact that there might be a problem with the doctor. Third, it would enable the GMC and the doctor's employer or PCT to discuss and/or clarify which organisation should proceed to deal with the complaint and to carry out any necessary investigation. I shall deal with these three issues separately.

Obtaining Background Information about a Doctor

18.150 In the past, when a complaint about a doctor's conduct, or notification of a conviction, was received by the GMC, it was not the practice to make any enquiries of the doctor's employer or PCO in order to discover whether there had been any previous expressions of concern about him/her. When Shipman's convictions were reported to the GMC in 1976, no enquiry was made of the Calderdale FPC in order to find out what its staff knew about Shipman, his abilities as a doctor or his drug abuse. It is clear from the evidence received by the Inquiry that it was not the practice at the time to make such enquiries. Under the old FTP procedures, it was not usual for any routine enquiry to be made when the GMC was notified that a doctor had been convicted of a criminal offence. If any enquiry was made, it was likely to relate to the circumstances of the offence (e.g. the level of alcohol in a case of drink driving or the amount of financial loss in a case involving a fraud on the NHS). It was unlikely to relate to the possible impact which the doctor's criminality might have had on his/her practice.

18.151 So far as complaints about conduct are concerned, those that come from employers or PCTs will often be accompanied by some background information about the doctor and any past problems associated with him/her. Members of the public do not have access to that sort of information. Their complaints are likely to relate to single, often apparently isolated, incidents. In the past, however, the GMC took no steps routinely to seek background information about a doctor who was the subject of a complaint by a private individual.

18.152 At the time of their initial work at the GMC, Professor Allen and her colleagues were concerned at the lack of any contact with the doctor's employer or PCO before a complaint against him/her was screened. Professor Allen told the Inquiry that it seemed to them that a 'quick phone call' to the medical adviser at the relevant PCO would have helped to put a complaint about a GP into perspective. It appeared to me that there were two ways in which background information about a doctor might have been very valuable. First, where the complaint was about a single episode involving conduct which, if proved, would amount to substandard clinical practice (although not, or not necessarily, SPM), it would be important to know whether the alleged incident was, so far as was known, a 'one-off' episode or whether there had been previous similar incidents of which the doctor's employer or PCT was aware. If there had been, this might, in the past, have suggested that the doctor should be referred to the GMC's performance procedures or, at the very least, that there should be some discussion between the GMC and the employer or PCT (and, possibly, the NCAA) about how the problem should be tackled.

18.153 The second way in which such background information might have been valuable was in assessing the potential seriousness of a complaint about a single incident. For example, a complaint might concern what appeared at first sight to be a 'one-off' error involving the use of a piece of equipment or a particular drug. The doctor might admit the error but might claim that, through no fault of his/her own, s/he was unfamiliar with the equipment or drug concerned. An enquiry of his/her employers or PCT might reveal an earlier similar incident with the same piece of equipment or drug. The information about the earlier incident would put the later one in an entirely different light. It might suggest a pattern of poor

performance. However, it might also suggest a lack of concern for patient safety such as would amount to SPM.

18.154 The 1997 Screeners' Handbook, published to coincide with the introduction of the performance procedures, specifically provided for enquiries to be made of employers and PCOs and of officials of local medical committees and the equivalent committees in hospitals. Such enquiries were, however, to be made only at the request of a medical screener. The suggestion was that they should be made in all cases unless it was clear from the outset what action should be taken under the FTP procedures or unless there appeared to be no basis for the GMC's involvement in the complaint. Certain rules were to be observed. In particular, no approach was to be made to any person who was not already aware of the complaint unless the doctor who was the subject of it had first been informed of it. Furthermore, it was to be made clear to the person of whom enquiries were made that the GMC was simply making preliminary enquiries and that no decision about possible GMC action had been taken.

18.155 The contents of the 1997 Screeners' Handbook seemed to suggest that enquiries of employers would be made virtually as a matter of routine in any 'borderline' case involving a complaint of substandard clinical practice made by a private individual. It is clear, however, that this was not done. Indeed, cases where such enquiries were made appear to have been very much the exception rather than the rule.

18.156 One reason for the failure to follow the practice set out in the 1997 Screeners' Handbook was that there was ambivalence about whether the GMC should be making such enquiries. I have already discussed this ambivalence in connection with the general issue of investigation. It was well illustrated in the evidence of Dr Korlipara. He was a medical screener between 1998 and 2004. He said that, following the publication of the 1997 Screeners' Handbook, there was general support for enquiries to be made, both to shed further light on a single complaint and to see whether that complaint was in fact part of a more general problem. The type of single complaint where further enquiries would be made was, he said, where the complaint was potentially 'seriously unacceptable' but where details were sketchy, so that further clarification was necessary. In other words, any enquiries of a doctor's employer or PCO would not be made in order to inform a screener's preliminary assessment of the complaint. Rather, they would be instituted after that preliminary assessment, if it appeared to the screener that the complaint had, of itself, the potential to amount to SPM or SDP.

Dr KE 10

18.157 Dr Korlipara was asked about a case (that of Dr KE 10) which illustrated this approach. A widower complained to the GMC about the treatment of his late wife by two GPs. He had previously pursued his complaint through the NHS complaints procedures. This had resulted, a year after the events complained of, in an IRP report which was critical of both doctors and of the organisation and management of their practice in a number of important respects. One of the doctors was subsequently granted voluntary erasure from the medical register so that, in the event, the GMC was left with the complaint in respect of Dr KE 10 only.

18.158 The complainant's wife had been suffering from a terminal illness which presented late and in an unusual manner. It was not suggested that Dr KE 10 or his colleague had caused her death or that the course of the illness would have been changed had they behaved differently. Nor was it suggested that they should have correctly diagnosed the precise nature of the patient's condition. An x-ray obtained by Dr KE 10, which might have been expected to show evidence of the condition if present, apparently showed only degenerative changes. However, the IRP found that Dr KE 10 had failed to keep clinical notes or records of an adequate standard, had failed to consider carrying out blood tests which would have been appropriate, and had refused reasonable requests for home visits. These failures, together with those of his colleague and of the practice generally, were said by the IRP to have contributed to the failure to recognise the seriousness of the patient's condition and to treat it with appropriate pain relief.

18.159 Dr Korlipara screened the case and advised that it should be closed. He referred to the result of the x-ray and observed that Dr KE 10 was justified in reassuring the patient on the basis of the x-ray report. He was satisfied that the terminal nature of the patient's condition could not have been appreciated until two days before her final admission to hospital. He did not comment on the specific findings of the IRP in respect of Dr KE 10, merely saying that his management of the patient's condition did not raise issues of SPM or SDP. The lay screener agreed.

18.160 It is clear that, apart from the IRP report and related documentation, and a letter written on behalf of Dr KE 10 by his medical defence organisation, Dr Korlipara had no other information before him. In particular, there was no background information about the doctor from the PCT. This was despite the fact that the IRP report had raised concerns which might, I should have thought, have been part of wider performance issues. I also note that the complainant had suggested in his evidence to the IRP that there were wider problems with Dr KE 10. This suggestion might or might not have been correct, but it seems to me that it should at least have prompted some enquiries of the PCT.

18.161 In oral evidence, Dr Korlipara expanded upon his reasons for advising that this case should be closed. I shall refer to this decision further in Chapter 19. Dr Korlipara was then asked about the failure to discover whether the PCT had any other concerns about the doctor's performance. He took the opportunity to express his general views about the appropriateness of the GMC making enquiries of a PCT. He said:

> **'... the GMC traditionally has received complaints. It has not instigated complaints other than if it has seen** (*them in*) **the press or in some public domain but, by and large, complaints have been referred to it and it has looked at the complaints and upon the merits of those complaints after careful analysis comes 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 stage. If the answer is no and it** (*is*) **an isolated complaint which of itself does not raise the spectre, we assume that in the case of National Health Service patients, which are**

either managed by the PCTs or its predecessors or the hospital trusts, they do have a duty and they would be doing their duty of informing us if they had any concerns unprompted.

... returning to the repeated question put to me as to whether the GMC should have initiated enquiries of its own of the PCT or the hospital trusts when the isolated complaint of itself really does not amount to any serious nature, I think it really takes it on to a newer level. People might describe it as fishing for further information of which the information (*I think this should be 'doctor'*) **against whom the complaint is made will have had no prior knowledge and yet which could be used in order to construct a case against a doctor. I am not really sure if the doctor's advocates would find that as in accordance with the natural law of fairness.**

Personally, I will have some difficulties unless some persuasive arguments are put to us in public that it is desirable and fair that additional information of which doctors have not been previously notified can be added to the complaints without the doctor having been made aware.'

18.162 In other words, Dr Korlipara was saying that it would not be fair to the doctor concerned to seek information from a PCT or NHS trust *before* a decision had been taken as to whether a complaint was likely to amount to SPM or SDP. If a decision was taken that it was likely to amount to SPM or SDP, further enquiries could be made. Otherwise, he suggested, it should be assumed that, had there been any concerns about the doctor, the PCT or the doctor's employers would have reported them to the GMC.

18.163 The problem with that approach, it seemed to me, was twofold. First, the background information might be necessary in order to answer the initial question of whether the complaint was likely to amount to SPM or SDP. Second, it might be that the PCT was dealing with a number of complaints or concerns about a doctor but was unaware of a complaint which had been made to the GMC by a private individual. The PCT might not have got to the point of reporting the doctor to the GMC. The information held by the PCT might nevertheless be of value to the GMC when deciding what to do with the complaint which it had received. Moreover, given the fact that the PCTs are relatively new organisations it would, I think, be unsafe to assume that they will always have a clear idea of what concerns they should and should not report to the GMC. From the viewpoint of patient safety, it seems to me to be clearly desirable that the GMC should have as complete a picture as possible before taking a decision on how to deal with a complaint. In any event, if there is to be a sharing of the regulatory function between the GMC and local NHS bodies, there must, in my view, be sharing of information relevant to that function. The making of assumptions by one organisation about information which may or may not be held by another does not appear to me to be in the interests of patient safety.

18.164 Dr Korlipara said that it was clear that Dr KE 10 had had many deficiencies which, although they did not in his view amount to SDP, needed correction. He said it was also clear that the practice was dysfunctional in a number of respects. He had assumed that the PCT

would have taken steps to deal with these problems. He said that it was not the GMC's role to oversee the PCT, so that it would not in his view have been appropriate for him to institute any enquiry about what had been done to address the shortcomings of the doctor or his practice. It seems to me that, in taking this rather narrow view of the functions of the GMC, Dr Korlipara failed to give proper weight to the need to protect Dr KE 10's patients. As the GMC is supposed to act in partnership with NHS bodies, it would surely have been sensible for an enquiry to be made about what steps, if any, had been taken to ensure that the doctor's deficiencies, and those of the practice, were remedied. If none had been taken, a letter of enquiry coming from the GMC might well have acted as a prompt to the PCT.

18.165 Mr Marshall said that, during the period between December 1998 and April 2000, a debate was going on in the GMC about whether background information about doctors should be sought when a complaint was received. He said that, in the light of some past cases, it had become apparent that the GMC was possibly failing in its duty to protect the public if such enquiries were not made. However, some members felt that there were difficulties in making enquiries at an early stage since this would involve disclosing to a doctor's employer or PCO the fact that a complaint had been made. It was eventually decided that discussions should take place only in certain cases, i.e. in those which were 'more performance-like cases'. Mr Marshall's evidence demonstrated the close link which was made with the GMC between the issues of seeking information about doctors from their employers and PCOs and of disclosing to those same persons or bodies the fact that a complaint about the doctor had been made to the GMC. The seeking of information was plainly in the interests of patient safety. The disclosure that a complaint was made was, however, perceived as unfair to doctors. His evidence also illustrates the existence of a conflict between the GMC's duty to protect patients and its desire to be 'fair to doctors'. It seems that, in that instance, the conflict was resolved by a compromise which went some way, but not far, towards the interest of patient protection.

Disclosure of the Fact that a Complaint Has Been Made

18.166 Early notification to a doctor's employer or PCT of the fact that a complaint has been made to the GMC has the effect of alerting that person or body to possible problems with the doctor. In the past, there was no automatic disclosure to a doctor's employer or PCO even when the complaint had been proved and the doctor had been the subject of disciplinary action by the GMC. Still less was there any disclosure of the fact that a complaint had been received and had been rejected or was in the process of being dealt with. NHS bodies would complain that the first that they knew of the fact that a doctor on their list or in their employment had been disciplined was when they read about it in the local newspaper. In December 1999, the GMC proposed in a consultation document that it should, in certain very limited circumstances, voluntarily disclose information about a doctor's involvement in its FTP procedures to employers and others with a legitimate interest in receiving that information.

18.167 The Government, however, favoured the creation of a statutory duty on the GMC to provide timely information to NHS bodies about doctors whose fitness to practise was being formally considered. As a result, from 2000, the GMC was placed under a statutory duty

to disclose to the DoH, and to any person or body by whom a doctor was employed or by whom s/he was contracted to provide services, any decision made by the GMC to refer the doctor to the PPC, to invite him/her to agree to an assessment of his/her professional performance or to invite him/her to agree to an assessment to determine whether his/her fitness to practise was seriously impaired by reason of his/her physical or mental condition. In other words, disclosure was to take place after screening of the complaint if a decision had been taken that the complaint was to be taken forward. Although a decision to refer a case to the IOC was not included in the list of triggers for disclosure, the Inquiry was told that, in practice, such a decision was treated in the same way as the other decisions specified in the new statutory provision.

18.168 At the same time, the GMC was given the power to require persons to disclose any information or documents in their possession which appeared relevant to the GMC's consideration of a case. This power could be used, in theory, to obtain information from NHS organisations, although one would have expected that such information would usually be provided voluntarily.

18.169 In addition, the GMC was given statutory power to disclose to any person information relevant to a doctor's conduct, professional performance or fitness to practise which it considered it was in the public interest to disclose. This power might be used, for example, where enquiries were made by a prospective employer about a doctor who was being considered for employment. It also enabled the GMC, if it considered it to be in the public interest to do so, to inform a doctor's employer or PCO of the fact that a complaint had been made against him/her, in advance of the stage in its procedures when it was obliged by statute to make the disclosure. This was important since, in some cases, a period of several weeks (or even longer) might elapse before a screening decision was made and the time for statutory disclosure was reached. In such cases, it might be desirable for the doctor's employer or PCO to receive advance warning of the complaint that had been made.

18.170 In evidence to the Inquiry, Mr Scott said that requests by the GMC to employers or PCOs for background information about doctors against whom complaints had been lodged were sometimes made and sometimes not. Even at the post-screening stage, where the GMC was obliged to disclose information about a complaint that had been made, the disclosure was not invariably accompanied by a request by the GMC for information from the employer or PCO. Sometimes, an employer or a PCT would volunteer information about a doctor but this was not always done. Mr Marshall said that, in the case of convictions, employers and PCOs would be notified of the fact that convictions had been reported to the GMC at the time they were referred to the PPC. If the GMC had reason to believe that the employer or PCO might have relevant information, direct questions would be asked of it. Otherwise, the GMC would rely on the employer or PCO to volunteer any information that might be relevant.

18.171 Mr Scott said that, since there was, at the time he gave his evidence in December 2003, no requirement imposed on the GMC to make a disclosure to an employer or PCO immediately a complaint about a doctor had been received, there was 'ambivalence' on the GMC's part about seeking background information at that stage. As a result, further

information was sought only if 'the decision-makers' (by which I assume Mr Scott meant the screeners) said they did not have sufficient information to make their decision without such enquiries. The reason for the 'ambivalence' referred to by Mr Scott was that, if enquiries were made of an employer or PCO when a complaint was received, this would disclose the fact that a complaint had been received before the GMC was required by statute to make that disclosure. It was thought that this was unfair to the doctor concerned. As I have explained, it is clear that the GMC had the power to disclose at an earlier stage the fact that a complaint had been made, if it considered that it was in the public interest to make the disclosure for the purpose of obtaining information from the doctor's employer or PCO. However, in most cases, it did not choose to use that power.

18.172 With the impending introduction of the new FTP procedures, the GMC had to reconsider the point at which its statutory duty to make disclosure of a complaint should arise. During the period for which the new procedures were under discussion, its proposals as to what stages of its procedures should trigger disclosure underwent considerable changes. I describe these changes – and the eventual outcome – in Chapter 25. Broadly speaking, the obligation to disclose the complaint to a doctor's employer or PCO will, in most cases, arise when the case is referred to a case examiner, who will fulfil a similar – but not identical – role to that of the current screeners.

18.173 Meanwhile, as I have explained, in May 2004, the GMC announced that it would thenceforth be making informal disclosure of the fact that complaints had been made in certain cases. The intention was to discuss certain complaints with the doctor's employers and PCO at an early stage. The purpose of these discussions would be, first, to discover whether the complaint was an isolated matter or was part of wider local concerns about the doctor and, second, to inform those with local clinical governance responsibilities that the GMC had received a complaint about the doctor. It was not intended that such discussions would take place in every case. They would not be held in cases which, in the view of the GMC, clearly did not require action, nor in those cases where it was immediately clear, because of their seriousness, that the GMC must investigate.

18.174 The type of case in which discussions should take place is one where the allegation is not of itself (even if proved) serious enough to justify action on registration, but where the GMC's view might be different if there were wider concerns at local level about the doctor's practice. In such cases, the GMC will enter into a dialogue with the doctor's employer before deciding whether to investigate further. If that dialogue discloses no wider concerns about the doctor's fitness to practise, the GMC might decide that it need not investigate further. It seems to me that these new arrangements should, if implemented consistently, bring about significant improvement in the GMC's preliminary decision-making.

18.175 However, reports in the medical press have suggested that the new arrangements have been greeted with dismay by doctors. It has been said that the informal disclosure to employers and PCOs of the fact that a complaint has been made would be 'unfair to doctors' since employers would be liable to draw adverse conclusions from the fact that a complaint had been made against a doctor. At least two medical defence organisations are reported to have challenged the right of the GMC to ask a doctor to provide

employment details for the purpose of enabling the GMC to contact his/her employers to discuss a complaint made against him/her before the time for statutory disclosure is reached. It remains to be seen whether the GMC will apply the new arrangements consistently in the face of such opposition from within the profession or whether it will apply them in only a minority of cases or whether, like the very similar arrangements that were described in the 1997 Screeners' Handbook, the new arrangements will fall into disuse.

Deciding Which Organisation Should Deal with the Complaint

18.176 An early discussion between the GMC and a doctor's employer or PCO about a complaint should enable a decision to be taken as to which organisation should assume responsibility for dealing with the complaint. I have referred at paragraph 18.104 to the advantages, in an appropriate case, of a direct referral by the GMC to the local complaints body.

Comment

18.177 It is disappointing that the GMC, which has the protection of patients as its declared objective, has been content for so long to look at individual complaints in isolation. There seems to have been a failure fully to appreciate the effect that knowledge about a previous complaint might have on the evaluation of a later complaint. It also seems that there has been a view, illustrated by Dr Korlipara's evidence, that it would be 'unfair to doctors' to seek background information which might, in some circumstances, be unfavourable to them. From the viewpoint of patient safety, it seems to me essential that, when a decision is being taken whether or not to institute disciplinary action, the person making the decision should have a full picture of all issues which may affect the doctor's fitness to practise.

18.178 I welcome the intention, expressed by the GMC, that it should have informal discussions with doctors' employers and PCOs at an early stage after a complaint has been received. If this is done, it should ensure that employers and PCOs are aware at an early stage of complaints made about doctors for whom they have a responsibility. This will alert them to possible problems with doctors and will enable them to take any necessary steps to protect patients. In addition, complaints can be a source of great distress and anxiety to doctors and it is important that their employers and PCOs are aware of the position so that they can offer any support and practical assistance which may be necessary. The arrangements should also enable the GMC to place a complaint in context and to be made aware if the problem complained of is part of a wider pattern of concerns or is more serious than it would first appear. I hope that the GMC will not be deflected from its present intention by opposition from the profession. I hope that it will use this option in the majority of cases, indeed in all save for those which are obviously trivial and which plainly do not give rise to any issues for the GMC or the local NHS body. I do not know whether the GMC intends to apply this policy to complaints about doctors working in the private sector. I hope that it will do so.

Some Problems with Cases Closed by General Medical Council Staff

18.179 Under the old procedures, about 65% of the complaints and other communications received by the GMC's Screening Section were dealt with by members of the GMC's

administrative staff, who were authorised to close them without reference to a medical screener. It was the casework managers who took the decision whether to close a case or to refer it to a medical screener. It was also the casework managers who decided what, if any, further information was required before a case was submitted to a medical screener. The casework managers worked to instructions set out in the FTP Casework (later the FTP Investigation) Manual and other documents.

18.180 As I have previously explained, the Inquiry requested and obtained from the GMC the last five cases prior to 30th September 2003 which had been closed by GMC staff and in which the complainants had been advised to refer their complaints to local NHS complaints procedures. The Inquiry also requested and obtained the last five cases prior to the same date where complainants had been advised to refer their complaints to private complaints procedures. I shall refer later in this Chapter to two of the latter cases, those of Dr KC 02 and Dr KC 05, where the doctors who were the subjects of the complaints had not been identified. I express my concerns about those cases at paragraphs 18.213–18.227.

Dr KC 03

18.181 Another within this group of five cases was that of Dr KC 03. The complaint in that case was that Dr KC 03 had sent to the complainant the results of certain medical tests, carried out in the course of the (private) treatment of a member of the complainant's family, without providing any explanation of the results. It was said that when the complainant spoke to Dr KC 03 and requested an explanation, the doctor had been abrasive and rude. The complainant asked that the doctor should be reprimanded. The case was closed by a GMC casework manager on the ground that it would be more appropriately dealt with under local complaints procedures.

18.182 Standing alone, that decision could not be criticised. However, there had been two earlier complaints made against the doctor. The first had concerned the doctor's employment practices. The second alleged that the doctor's performance in private practice gave cause for concern. In connection with the second complaint, the GMC had written to the doctor, informing him that the medical screener was considering referring the doctor for a performance assessment and seeking his observations. (This letter was written under rule 5 of the General Medical Council (Professional Performance) Rules Order of Council 1997, a provision which was repealed in 2002.) The doctor submitted an extensive reply on the basis of which the medical screener decided that an assessment would not be necessary, given the doctor's insight into his problems and his ongoing attempts to address them.

18.183 Mr Marshall explained that, when the most recent complaint against the doctor was triaged, the casework manager should have been aware that previous complaints had been made about the doctor since this was noted on the CDF. However, he said that it was not clear from the relevant documents whether the casework manager had referred to the papers relating to the previous complaints before making a decision on the current one. Mr Marshall would have expected this to be done in view of the fact that one of the previous complaints had given enough cause for concern for a rule 5 letter to be sent. The most recent complaint cast doubt on the belief that the doctor was addressing his problems

successfully. Mr Marshall said that, if the casework manager had been aware of the previous complaint, he should at least have checked with the doctor's current employers or colleagues to ascertain whether there were any ongoing concerns about his practice. After the case came to light, as a result of the Inquiry's investigations, Mr Marshall caused it to be reopened so that the GMC could make appropriate enquiries.

18.184 This was a case where a previous complaint which was plainly of relevance to the one under consideration was probably not examined. As a result, the potential significance of the subsequent complaint was not recognised and the case was closed. It is of particular concern that the GMC should have failed to make appropriate enquiries in a case involving possible performance problems with a doctor in private practice. Such problems are less likely to come to light and be dealt with in a private setting than within NHS structures. When they are revealed, therefore, they should be given especially careful consideration.

Dr KE 05

18.185 When examining GMC files relating to doctors who had been the subject of disciplinary action for drug abuse, the Inquiry, by chance, came across a number of cases where other complaints against the same doctors had been closed by members of the GMC staff. One example of such a case was that of Dr KE 05, a GP. The GMC received a letter from a HA, expressing concern about Dr KE 05's high level of prescribing of morphine. Following Shipman's conviction, the Medical Adviser to the HA had carried out an analysis of the prescribing of morphine by doctors in the area. This had shown that Dr KE 05 had been prescribing over ten times more morphine than the average amount prescribed by other doctors/GP practices in the area. The Medical Adviser reported that a rumour had been circulating that the doctor had had 'dealings' with drug addicts. The doctor had since left the area covered by the HA in question.

18.186 The GMC requested further information from the HA, and this was provided. Eleven months later, the GMC sent a 'holding' letter. After a further 11 months (and almost two years after the original complaint), a member of the GMC staff wrote asking for **'any additional documentation'** relating to the complaint. This kind of delay was fairly common in cases that were dealt with by the GMC at that time. It seems that this letter was written following a Screening Case Review which had resulted in a recommendation that, because of its subject matter, the case should be progressed **'as a matter of priority'**. The HA responded promptly, saying that it had no further documentation in its possession. Shortly afterwards, the case was closed on the ground that it was a complaint from a third party **'where it is clear that the principal party does not want to pursue the matter, and no other reason for proceeding'**.

18.187 One striking feature of this case was the absence of any investigation by the GMC. The only action initiated by the caseworker was to ask for information and documentation from the HA which had raised the concern. There appeared to have been no real understanding of the type of documentation or information that would have been of assistance. Clearly, what was required was prescribing data relating to the doctor's past and current prescribing. If the HA did not have the data, it could have been obtained from

the Prescription Pricing Authority (PPA). If the request had been made quickly enough, prescription forms could also have been obtained from the PPA. No attempt was made to do this. Moreover, there was no attempt to find out where, and in what circumstances, the doctor was working at the time he was reported to the GMC or to contact his current employers or PCO.

18.188 The GMC might not have been the appropriate body to undertake an investigation of this kind. It might have been better done by the Home Office Drugs Inspectorate. If that was the case, there was no recognition of that fact and no attempt to direct the case to the proper quarter. Instead, the GMC acted as the passive recipient of information and, when the complainant appeared to have no more information to offer, the case was closed. The fact that a member of the GMC staff considered that there was **'no other reason for proceeding'** in a case involving the possible unlawful supply of controlled drugs is extremely worrying.

18.189 Dr Korlipara acknowledged to the Inquiry that there had been a 'serious lapse' in this case. Subsequent to it, in his capacity as a medical screener, he had had to consider a further complaint against Dr KE 05. This had involved an allegation of substandard clinical practice and was not drug-related. Dr Korlipara was informed by GMC staff at the time of screening that there had been two previous complaints against the doctor. The first in time had been referred to a medical screener; Dr Korlipara saw the papers relating to that complaint and did not consider it relevant to the one he was considering. On being told that the second previous complaint (the morphine case) had been closed by GMC staff, Dr Korlipara did not look at it. Thus, he remained unaware of the complaint about possible over-prescribing of morphine until he reviewed the file for the purpose of making a written statement to the Inquiry.

18.190 The practice of not considering cases which had previously been closed by GMC staff caused me some concern. I do not criticise Dr Korlipara personally for his failure to look at the earlier complaint. I have no doubt that he was following the usual practice. However, many cases were closed by casework managers, not because they contained no allegation of substance, but because they had not yet passed through the local complaints procedures. The majority of cases closed for that reason would have involved allegations of poor treatment or substandard clinical practice. It seems to me desirable that the person performing the screening function (in future, a case examiner) should have the fullest possible picture of the history of any previous dealings which the doctor may have had with the GMC's FTP procedures before taking a decision as to whether a case should go forward. In this context, I was concerned to hear that, at one stage in the 1990s, the GMC had embarked upon the process of disposing of the documentation relating to old complaints that had been closed. Fortunately, the process was discontinued. I can well understand the desire to clear out old documents to make space for new ones. However, it does seem to me that information about all complaints about a doctor should be retained (in some form) while that doctor remains on the register.

18.191 Returning to the complaint against Dr KE 05 of possible over-prescribing of morphine, Mr Marshall said that the decision to close the case was 'clearly wrong'. The member of staff who had taken the decision no longer worked for the GMC. Since the matter came

to light, the case had been reopened and enquiries instituted. Mr Marshall described as 'minimal' the possibility that at the time when he gave his evidence, a decision to close the case would have been taken in the same circumstances. This was, first, because casework managers were better trained. Second, he said that the system of triage which had operated since October 2002 meant that new cases were considered by a relatively senior member of staff (a casework manager) at an early stage. The casework manager would give instructions about action to be taken, together with the timescale within which that action should be completed. In all cases where complaints had been referred by healthcare providers, staff had been instructed to contact the referring body to discuss how the case should be dealt with. In addition, weekly meetings between caseworkers and their casework manager were held, at which all 'live' cases were discussed, priorities agreed and weekly objectives set. Mr Marshall also said that the audit procedures for cases handled by the Screening Section, to which I have already referred, should assist in eliminating any potential inconsistencies and errors made in the closure of cases at an administrative level.

Dr KH 02

18.192 An error or omission by a member of the GMC staff which results in a failure to obtain or take note of relevant information about a doctor may have an important effect upon the course of any subsequent proceedings. One such case of an error by a member of staff came to light by chance as the result of the Inquiry's consideration of a case (that of Dr KH 02) that had entered the health procedures. In the late 1990s, a complaint was received about Dr KH 02 to the effect that he had been drunk at work. The medical screener, Dr Korlipara, referred him into the health procedures. Unbeknown to Dr Korlipara, a few months before this complaint had been received, the GMC had been notified that Dr KH 02 had recently been convicted of the unlawful possession of cannabis and cocaine. Had Dr Korlipara known of these convictions, it is likely that his decision would have been different and that the case would have been referred to the PPC. In the event, the doctor's progress in the health procedures had not been good and, at the time when this error came to light, during the Inquiry hearings in 2003, his future in medicine was in doubt.

Dr JN 01

18.193 Another case which gave rise to concerns about actions taken by GMC staff was that of Dr JN 01. A HA informed the GMC of concerns relating to Dr JN 01, a GP, who was said to be issuing, in suspicious circumstances, large numbers of NHS and private prescriptions for benzodiazepines and other drugs. Subsequently, the HA sent to the GMC information from one pharmacy which showed that the doctor had issued 329 private prescriptions for benzodiazepines over a ten-month period. The HA sent the GMC a dossier of evidence relating to Dr JN 01's prescribing and also to two further complaints (one of theft from a patient) which had been made about him.

18.194 Before the case was referred to the GMC, investigations had been undertaken by the police and by the PPA Pharmaceutical Fraud Team (PPAPFT). On receipt of the referral,

the GMC took no action itself but awaited the outcome of the other investigations. A GMC caseworker met a representative from the PPAPFT. After that, it was decided to await further information from the PPAPFT before considering what to do next. The GMC file contained conflicting information as to whether the police investigation was continuing. However, the GMC made no direct contact with the police, despite the fact that the GMC had a team of staff whose task was specifically to liaise with the police. Mr Marshall said that he thought that the failure to refer the case to the specialist team occurred because the case was referred initially as a complaint of 'strange prescribing', rather than as a conviction case.

18.195 Seven months after the report was received by the GMC, the case was closed administratively. This did not mean that it was necessarily at an end. Instead, the intention of the GMC apparently was that it would be reviewed monthly and that regular enquiries would be made of the PPAPFT to ascertain what stage its investigation had reached. The GMC's computer system permitted a case to be 'flagged' for action periodically. However, it appears that this was not done. Two months later, following an enquiry from the HA, the GMC wrote to the PPAPFT, asking about progress. After a further four months, the PPAPFT informed the GMC that it had concluded its investigations. Four months later, the GMC was told that the local PCT (which had by this time replaced the HA as the PCO) was considering evidence collected by the PPAPFT and was making further enquiries about the doctor. The GMC still took no further action and the case remained closed until it came to light a few months later as a result of the Inquiry's request for documents.

18.196 Mr Marshall acknowledged that the handling of the case by the GMC had been deficient at two points. First, he said that the case should not have been closed administratively. That closure had resulted in a failure to chase up the PPAPFT for information. Second, after contact with the PCT, no further action was taken. The explanation was, he said, 'that we (*i.e. the GMC*) have either consciously made a decision that we have had three stabs at this and this is the last time we are going to bother ourselves to do it, or it has simply disappeared from view as other priorities took over'. He said that, if the case had not been closed, it would have been reviewed every week by the casework manager and a caseworker. Because the case was closed, it was not subjected to that routine review and was not the 'nagging irritation' it would – because of its age – have been at such meetings. The impression I received was that it was probably to avoid that 'nagging irritation' that the case was closed in the first instance.

18.197 Once the failure to follow up the case came to light as a result of the Inquiry's investigations, the case was reopened. Mr Marshall said that the GMC had obtained a full update from the PCT, which continued to monitor the doctor. Officers of the PCT had told the GMC that they did not feel that patients were at risk as a result of the doctor remaining on the register and being allowed to practise unrestricted. Mr Marshall told the Inquiry that he thought that the GMC needed to ask more questions of the PCT. In particular, it needed to find out whether any explanation had ever been obtained for the 'strange lurch in prescribing activity' that had occurred. It also needed to know what the position was in relation to the other two outstanding complaints against the doctor.

18.198 Mr Marshall said that it would not have been appropriate under the old FTP procedures for the GMC to have undertaken any investigation of its own (e.g. by instructing its

solicitors to investigate) at or before the screening stage. In any event, he did not think that the solicitors would have had the powers necessary to mount an investigation of this kind. Unless an investigation had been undertaken by another body and an explanation for the doctor's prescribing habits identified, it would, he said, have been difficult for charges against the doctor to be formulated by the GMC. It would not have been clear to the GMC what the doctor should be charged with, since it was not known whether the prescribing was the result of criminality or incompetence or was entirely innocent.

18.199 The handling of this case gave rise to a number of concerns. I can well understand the difficulty the GMC faces where other bodies are engaged in investigations, particularly where the doctor concerned is unaware that those investigations are going on. It is obviously important that the GMC does not prejudice the outcome of other investigations, in particular police investigations. It is also important, however, that the GMC has a clear picture of which organisation(s) is/are investigating and which issues they are investigating. It is in my view extraordinary, in the present case, that the GMC had no contact with the police and that it neither requested nor obtained a copy of any report prepared at the conclusion of the police investigation. It might be that the GMC staff assumed that the police had decided not to prosecute the doctor. However, that fact would not mean that there were no issues that the GMC ought to address. Nor did the GMC obtain any report on the evidence collected by the PPAPFT. There seemed to be no recognition of the fact that the PPAPFT investigation would be concerned only with potential fraud on the NHS (and, therefore, only with the NHS prescriptions issued by the doctor), not with the doctor's private prescribing.

18.200 The failure by the GMC to investigate rendered it entirely dependent on the result of investigations carried out by other bodies. If, as appeared to be the case here, those results were inconclusive, it seems that the GMC regarded itself as powerless to act. This was despite the fact that the purpose of disciplinary proceedings by the GMC – to ascertain whether the doctor is fit to practise, and to protect patients – is wholly different from the purpose of the other investigations which were undertaken. Mr Marshall suggested that the problems of dealing with a case such as this would be ameliorated by the introduction of the new FTP procedures.

18.201 Another obvious concern was the premature closure of the case. The purpose of that closure may have been to avoid the very procedures which had been designed to ensure that cases were not overlooked and left inactive for long periods. The system of flagging a case for review did not appear to have been implemented. The effect was that, had it not been for the Inquiry bringing the case to light, it might have lain dormant indefinitely, despite its potential seriousness. Even when it was brought to the GMC's attention, it did not appear that the GMC was intending to embark upon any investigation of the case. Rather it seemed content to let the PCT continue its attempts to resolve it. This is despite the fact that the evidence of the private prescriptions alone must, at the very least, have raised doubts about this doctor's fitness to practise.

Comment

18.202 I do recognise that every organisation makes mistakes. The Inquiry has not carried out an audit of cases closed by casework managers; it has examined only a few cases, which

have come to its attention by chance. It is possible that the Inquiry has, by chance, alighted upon isolated incidents of poor practice. However, the results of the audit exercise recently begun, which I described at paragraph 18.46, would suggest that errors and poor practice are not uncommon. It is comforting to know that some audit is now taking place. However, while mistakes are still being found, I wonder whether the audit should not become a review and should encompass all decisions rather than only a proportion of them. It seems to me that correct decisions in these cases are important to patient safety.

18.203 The cases I have described also illustrate the real problems caused by the lack of any investigation by the GMC. Within the small selection of cases examined by the Inquiry, two potentially serious cases were found, both involving allegations of improper prescribing of controlled drugs. Both were closed without any investigation by the GMC. Either or both of those doctors could pose a continuing risk to patients.

Ascertaining the Identity of a Doctor Who Is the Subject of a Complaint

18.204 One of the first tasks which the GMC staff undertake when a complaint is received is to seek to establish the identity of any doctor named or described in the complaint, by reference to the medical register. This is not necessarily as simple as it sounds. It may appear surprising that a complainant should not be able to identify a doctor about whom s/he is complaining. However, it is not unusual for a patient in a hospital to be unaware of the identity of the doctors who treat him/her, nor for a patient attending a 'walk-in' clinic to be similarly unaware. Nor is it uncommon for a complainant to supply a name to the GMC which turns out to be wholly or partially incorrect. Identification can also be a problem where there are several doctors on the register with the same or a very similar name. It is rare for a member of the public to be in a position to quote a doctor's GMC registration number, which might be necessary to identify the doctor positively in these circumstances.

The Work of the Policy Studies Institute

18.205 When Professor Allen and her team first began their studies of the GMC procedures, they noted that a significant proportion of the doctors against whom complaints had been made had never been identified by reference to the GMC's medical register. Plainly, if the GMC's procedures were to be thoroughly examined for racial bias, it was important that the doctors complained about should be identified. A good system of identification is also necessary if the GMC is to fulfil its public protection duties. The 1996 PSI Report recommended that the GMC should enter and store on computer, for the purposes of monitoring, full details of the doctors about whom complaints had been made and that those details should be matched and linked with the medical register.

18.206 Despite this, the 2003 PSI Paper pointed out that there had in fact been an increase since 1997 in the proportion of doctors complained about whose identity had not been established by the GMC. In 1997, complaints were made against 2485 doctors, of whom 377 (15%) were not identified. By 2001, the number of doctors complained of had risen to 3999, of whom no fewer than 1019 (just over 25%) had not been identified. Professor

Allen told the Inquiry that the GMC's explanation for the increase in unidentified doctors was that it was thought unnecessary to identify doctors in cases which were closed by the administrative staff and which the GMC considered could never raise a question of SPM or SDP. Professor Allen and her colleagues noted with surprise that the GMC's categorisation of the complaints made against 22% of the unidentified doctors (in cases where there had been a categorisation of the complaint) had been **'dishonesty/criminality'**. A fairly high proportion of complaints in this category had not been sent to a medical screener. I find it worrying that so many doctors remained unidentified, especially in cases involving allegations of dishonesty or criminality. It is also a matter for concern that they were not referred to the medical screeners. Moreover, in each year, about 10% of the doctors who had not been identified had been reported to the GMC by public bodies. This was particularly surprising because it is hard to imagine that a public body would make a complaint about a doctor without being aware of the doctor's identity.

The Problems Caused by the Failure to Identify Doctors

18.207 Since Professor Allen and her colleagues were looking at the possibility that racial bias might play a part in decisions made by the GMC, the failure to identify doctors was of particular concern. In their various analyses, they had looked at the country of qualification of all doctors who were the subject of complaints to the GMC. They had then compared the outcomes of the complaints against those who qualified in the UK with the outcomes of the complaints against those who had qualified overseas. Failure to identify a doctor meant that the country of qualification of the doctor could not be identified. Professor Allen and her colleagues were concerned that no similar analysis of cases would be possible in the future if doctors and their countries of qualification were not identified.

18.208 There are other consequences of the failure to establish the identity of a doctor against whom a complaint is made. First, it means that the GMC cannot ascertain whether the doctor has any previous history of complaints made to the GMC about him/her or of disciplinary action taken against him/her. Yet there will be many cases where knowledge of a doctor's FTP history might cause the current complaint to be viewed in a different light. Second, it means that the complaint cannot be retrieved in the future if another complaint against the same doctor is received. Third, it might be that the complaint involves a person who is not on the GMC's register but is masquerading as a doctor. If no attempt is made to check that the person complained about appears on the register, the fact that s/he is an impostor will never be known.

Possible Reasons for the Failure to Identify Doctors

18.209 In his evidence to the Inquiry, Mr Scott suggested two possible reasons for the apparently high number of unidentified doctors. First, he suggested that the doctor's identity might in fact be known but the name might just not have been recorded on the GMC database. I find it surprising that this could occur since I should have thought that the name of the doctor was a vital piece of information for reference purposes. The omission to record a name on the database may have serious consequences since it will be impossible to make

a link with another complaint about the same doctor in the future. There does not seem to me to be any excuse for a failure to record on the computer database the identity of a doctor if it is known.

18.210 Second, Mr Scott said that a significant proportion of communications received by the GMC were not complaints against doctors but were pieces of correspondence raising issues which, if a doctor were involved, could become a complaint. Quite a high proportion of those did not involve a doctor at all. I can see that, in those circumstances, it would not be necessary (or, in some cases, possible) to link the subject of the complaint with a name on the medical register. However, the complaints referred to by Professor Allen (particularly those involving **'dishonesty/criminality'** and the reports from public bodies) must have involved allegations against the doctors concerned; they cannot have been just general correspondence.

18.211 Mr Scott said that there was a procedure to be followed when trying to identify a doctor. The extent to which that procedure was implemented depended on the potential seriousness of the issue that had been reported. If it was of sufficient seriousness to be a potential candidate for the FTP procedures, staff would go to some lengths to identify the doctor. If the complaint did not, on the face of it, raise an issue that would fall within the FTP procedures, then correspondingly less effort would be devoted to trying to identify the doctor. That approach does not sound unreasonable but it does not account for the failure to identify doctors about whom the complaint was of **'dishonesty/criminality'**. Moreover, examination of a few individual cases suggests that abandonment of an attempt to identify a doctor may sometimes be premature.

Specific Cases

18.212 The Inquiry examined two cases that illustrated the problems arising from a failure to identify a doctor about whom a complaint has been made. Both were closed by casework managers in late 2003.

Dr KC 02

18.213 In the first case (that of Dr KC 02), the complainant had undergone laser eye treatment at a private clinic. She alleged that, as a consequence of the treatment, she had suffered scarring to her eye. She was complaining of distortion of vision. In a letter to the complainant's GP, written after he had been notified of the complainant's dissatisfaction, the person who performed the treatment (whom the complainant understood to be a doctor) had claimed that the complainant had been warned of the risks of a poor outcome before undergoing the treatment. The complainant said that she had not been warned. She had initially directed her complaint to the General Optical Council, which had forwarded the complaint to the GMC since the subject of the complaint appeared to be a doctor.

18.214 The case was closed by GMC staff on the ground that local complaints procedures had not been exhausted. In a letter written by a casework assistant, the complainant was advised to refer her complaint to the Medical Director or Chief Executive of the clinic

where she had received her treatment. The letter also suggested that she might wish to copy her complaint to the NCSC, which would monitor the handling of the complaint.

18.215 The complainant had given the name of the person who had treated her. The name was an unusual one. Yet the caseworker who dealt with the complaint had not been able to match the name with that of a doctor appearing on the medical register. It appeared to me that this immediately raised the possibility that the person who had treated the complainant had not been a doctor at all. Of course, it might be, as Mr Marshall suggested, that the complainant had spelled the name wrongly and that this was why the name could not be found on the medical register. However, it was impossible to be sure.

18.216 Mr Marshall said that, once a decision had been taken that the GMC would not be proceeding in the case, it would have been an unnecessary expenditure of resources to attempt to identify the doctor. I can understand that, in some cases, it might not be worthwhile expending resources in this way. However, in this case, where the GMC had the address of the clinic where the treatment had been given, the task of ascertaining the doctor's details would have been relatively simple. If that was not done, the possibility remained that the person who had performed the treatment was not a doctor at all.

18.217 If the person who treated the complainant had been an impostor, pretending to be a qualified doctor when he was not, he would have been liable to prosecution. Given that the role of the GMC is to protect patients, I should have thought it would have a keen interest in detecting and initiating action against any person who impersonated a doctor. If, an enquiry having been made of the clinic, it had appeared that the person who had treated the complainant was not on the medical register, the next step would have been to report the case to the police for investigation. Indeed, had the doctor not been on the register, that fact should have triggered investigations into the clinic, its recruitment policy and its staffing arrangements. The GMC itself could not have carried out such investigations but could presumably have asked the NCSC to do so.

18.218 The complaint was primarily one of negligent treatment. Even if the treatment itself had not been negligent, then there might have been a negligent failure to inform the complainant of the risks associated with the treatment. Both would be serious matters. If the subject of the complaint was indeed a doctor, the failure to identify him made it impossible for the GMC to ascertain whether there had been any previous complaints against him. It is possible that there had been a history of past complaints of a similar nature. In addition, if the GMC received another complaint of a similar nature about the doctor in the future, there would be no means by which that complaint could be linked with the previous one.

18.219 Mr Marshall pointed out that the failure to identify a doctor was not an unusual occurrence. Often, the name of the doctor was a common one and the problem lay in ascertaining which doctor of that name was involved in the complaint. Because the situation that arose in this case was commonplace, this case would not necessarily have 'rung alarm bells' with the caseworker. Having looked at the case afresh, Mr Marshall recognised the possibility that the 'doctor' might not in fact have been registered. He felt that the GMC should look at its processes with a view to setting out criteria for the circumstances in which more vigorous attempts should be made to identify a doctor about whom a complaint had been made.

18.220 This complaint concerned treatment in a private clinic, into which members of the public could walk without referral by, or advice from, a GP. Patients in those circumstances are particularly vulnerable and I should have thought that the GMC should be especially rigorous in protecting them. I find it concerning that the GMC's processes allowed the question of whether or not the person who treated the complainant was a *bona fide* doctor to go unanswered. I note also that the complaint was referred to the clinic's complaints procedures at a time when the GMC was in no position properly to assess the seriousness of the complaint or whether the doctor (if doctor he was) presented any danger to patients attending the clinic for treatment in the future. Nor did the GMC have any knowledge of the complaints procedures in operation at the clinic or whether they were likely to identify a possible threat to patient safety, if such a threat existed.

18.221 Moreover, the onus of initiating the complaints procedure was on the complainant. She had already indicated that she had been unable to get a satisfactory response to her complaint from the clinic. It would not perhaps have been surprising if she had been unwilling to make another approach. If the GMC had forwarded her complaint direct to the clinic and had made it clear that it would be following the matter up to discover the outcome, the burden would have been removed from the complainant and there would, I should have thought, have been a greater chance of her complaint being taken seriously.

18.222 This case provided an interesting insight into the GMC's attitude to the gathering of information. During his evidence about this case, Mr Marshall made the point that it would be onerous for the GMC, and potentially disappointing for complainants, if the GMC were to enter into 'lengthy correspondence' with complainants in order to try to establish the identity of a doctor in such a case as this, where the GMC was not going to take the case forward. Plainly, it had not occurred to Mr Marshall that the GMC itself might take the initiative and might seek information from a third party, in this case the clinic. It seemed to be the case that 'investigation', to members of the GMC staff, was essentially confined to seeking information either from the complainant or from the doctor against whom the complaint had been made. This was perhaps not surprising, since it reflected what had, in general, been the practice in the past.

Dr KC 05

18.223 In the case of Dr KC 05, a member of the public wrote to the GMC, saying that she had undergone, at a private hospital, an orthopaedic operation which had had a very unsatisfactory outcome. The nature of the unsatisfactory outcome was unspecified. She was pursuing a claim for negligence against the surgeon concerned but wanted the issue of his fitness to practise to be considered by an appropriate authority. She did not name the surgeon involved or the hospital.

18.224 The case was closed by a casework manager and the complainant was advised to contact the Medical Director or Chief Executive of the hospital concerned and to ask him/her to look into the issues. She was told that she could return to the GMC if she was dissatisfied with the response. In this case also, it was suggested that the complainant might copy her complaint to the NCSC. She was not asked for the surgeon's name and the GMC did not establish his identity. The casework manager who closed the case had no idea whether

the surgeon had a history of complaints of a similar nature or a record of disciplinary action against him. The complaint of a poor outcome to the complainant's operation might or might not have been justified. If there had been a poor outcome, it might or might not have been as a result of substandard treatment on the surgeon's part. If it was, that substandard treatment might or might not have amounted to SPM. If there had been a previous history of similarly substandard practice, the opportunity of linking that history to this complaint (and possibly of discovering a pattern of SDP) was lost. Similarly, if a further complaint of the same type were received in the future, there would be no way of linking it with this one.

18.225 Mr Marshall said that he thought it would have been preferable if the GMC's letter to the complainant had specifically asked her to provide the surgeon's details so that checks could be carried out. He said, 'I think we hope that this particular complainant may come back to us.' I do not believe that the complainant would have understood from the letter which she received that an immediate return to the GMC was an option. The letter merely suggested that she could contact the GMC again if she was dissatisfied with the response she received from the hospital. Mr Marshall pointed out that an unsatisfactory outcome to an operation might not necessarily raise any issues affecting the doctor's practice and that, if there were such issues, they might not be at the appropriate threshold for the GMC to become involved, at least in the first instance. I accept that entirely, of course. The problem, it seems to me, is that, at the time the decision to close the case was taken, the GMC did not have the information necessary to make these judgements.

Comment

18.226 If the GMC is to be in a position to link a doctor against whom a complaint is made with any past FTP history which s/he may have and with any such history that s/he might acquire in the future, it is vital that a full and accurate record is maintained of the details of that doctor. I accept of course that, on occasion (particularly where the complaint relates to hospital treatment), it may not be possible to identify the doctor concerned. I also accept that there will be cases where no issue of patient safety could possibly arise or where there are other circumstances which mean that it would be a complete waste of resources to go to elaborate lengths to identify a doctor about whom a complaint has been made. However, it seems to me to be an entirely different matter where, as in the two examples I have cited, potential issues of patient safety do arise and complaints are being closed not because there is no substance in them, but because the GMC prefers to leave the task of investigating and assessing the seriousness of the complaint to local complaints procedures. In both cases, the task of ascertaining the identity of the doctor should have been perfectly simple. In both cases, the existence of a history of similar complaints could have been very significant.

18.227 Mr Marshall told the Inquiry that he thought that the GMC needed to reconsider its policy in relation to cases that were closed for referral to local procedures. In particular, there needed to be consideration of whether more energy should be expended on identifying the doctor. The Inquiry has been told that, since its hearings, the GMC has taken steps to address the problem of unidentified doctors and, certainly, the FTP Investigation Manual of May 2004 laid more emphasis than did previous similar publications on the importance of identifying a doctor against whom a complaint was made. I do not know how successful

the measures taken by the GMC have been. It seems to me surprising, however, that the GMC did not appear to appreciate – until the Inquiry drew attention to the fact – the implications for patient safety consequent upon its failure to establish the identity of such a high proportion of the doctors about whom complaints were made.

Conclusions

18.228 In this Chapter, I have examined the early stages of the GMC's 'old' conduct procedures in some detail and have been very critical of some of the practices, and of the policies which have underlain their operation. It may be said that this detailed examination of how the procedures have worked has been pointless and the criticism misplaced, because the conduct procedures have been abolished; the new FTP procedures will be much better. However, in my view, it has been important to conduct this examination because it has provided the best opportunity to understand how the procedures actually operated in the past as opposed to how they were theoretically intended to operate. There was, as I have indicated, a considerable difference between the two. For the future, I have received evidence about how it is hoped and intended that the new procedures will operate. In the nature of things, there is bound to be some shortfall between the intentions and the reality. I needed to know about any shortfall in the past in order to assess how the new procedures might actually operate in future.

18.229 The evidence has also revealed much about the attitudes and approach of the GMC over the years. Although the GMC has recognised the need for change, not only of its procedures but also of some of its old attitudes, I have needed detailed evidence of the old attitudes if I am to form a view of the chances of success for the new regime.

18.230 My overwhelming impression of the staff employed in recent years is that they are conscientious and sympathetic to patients. They did not seem to me in any way dismissive of patients' interests and concerns and I certainly detected no underlying desire to 'do patients down'. But it does seem to me that the GMC, as an institution, has been incapable of devising and operating its procedures and policies from the viewpoint of patients and patient protection. This is a thread that runs through all the issues I have discussed above. When, at the Inquiry, a problem was drawn to the attention of a member of staff, the reaction was usually to see the point and to accept that a different approach was required. An example is the feature that I have just described: the failure to identify 25% of doctors about whom complaints were received. Yet the problems were not recognised by the organisation itself until they were pointed out. I am not sure why not. There are several possibilities.

18.231 I recognise that an organisation can become set in its ways and so used to doing things in a certain way that it fails to notice that there is anything wrong with its methods, procedures and attitudes. But this cannot be said of the GMC. In the last five years, the GMC has faced up to the fact that its FTP procedures are inadequate and that they require radical reform. It has spent a great deal of time and effort devising new procedures and consulting upon them. It claims to have recognised the need to place the protection of patients in the forefront of all it does. Yet it did not see that many aspects of its old FTP procedures required change – change that did not need an Act of Parliament or the

expenditure of large amounts of money to bring about. A case in point was the practice of advising complainants to pursue local procedures and then just leaving them to get on with it. Mrs Robinson pointed out the difficulties and dangers of this practice in 1988. Yet it survived, little changed, for more than 15 years after that.

18.232 Another possibility, which I mention only to dismiss, is that members of the GMC staff do not have the intellectual resources to grapple with these problems. I have the impression that the GMC employs some extremely able staff. I do not think that is the problem. It is also apparent that leading members of the GMC, such as the current President, Sir Graeme Catto, and his predecessor, Sir Donald Irvine, are personally committed to providing FTP procedures that protect patients.

18.233 A further possibility, which I believe to be the root cause of the problem, is that there are inherent tensions between the interests of patients in having first class FTP procedures and the interests of the doctors who elect the majority of members of the GMC. There are two obvious sources of tension. One is money. The GMC is funded by doctors, and good FTP procedures, including good investigation, are an expensive business. The other is even more fundamental. I can understand and sympathise to some extent with the view of a doctor who asks why s/he should be expected to pay (and pay dearly) for a process that is designed primarily to protect the interests of another group (those of patients) which sometimes appear to be inimical to the doctor's own interests. The answer, of course, is that, if the profession wants to be in charge of its own regulation, it must pay for it and it must do the job to the satisfaction of the community at large. If the profession is not prepared to do the job in a way that properly protects the public and does not want to pay for a first class process, the Government may eventually decide that the profession will have to give up self-regulation.

18.234 Another facet of the problem seems to me to be that many doctors perceive the GMC not as their regulator but as a representative body. This perception is fostered by the way in which the majority of members are elected by the profession. If the doctors elect the members and pay for the whole operation, one can see why they expect the GMC to conduct itself in a way that favours the interests of the profession. The practice of electing members began in the 1970s following a near revolt within the profession at the introduction of an annual retention fee. The cry was 'no taxation without representation': hence the misunderstanding as to the role of the GMC. A possible solution to this is that the GMC should not be dominated by elected members but by leaders of the profession who are not beholden to an electorate.

18.235 I mentioned also that one of the problems that appeared to beset the GMC was its internal confusion about its role and its relationship with patients and the public. It has given the public the impression, in particular in its leaflets 'A Problem With Your Doctor?' and 'Referring a doctor to the GMC – a Guide for Patients', that it is a repository for all types of complaints and concerns about doctors. Yet its statutory powers and duties have been limited to dealing with complaints and concerns that give rise to a question of SPM, SDP or serious impairment to health. That was all the old FTP procedures were designed to do, although the GMC staff would also provide advice to callers. In this context and, as a further example of the way in which the GMC has reacted to concerns expressed by the

Inquiry, I notice that a new – and more accurate – description of the GMC's functions in respect of complaints and concerns has recently appeared on its website. When speaking of the old leaflets, Mr Scott said that there had been a lack of clarity in the GMC about where to position itself in relation to other systems, in particular the NHS complaints procedures. I wonder whether the 'lack of clarity' did not in reality represent a conflict of views between its members as to the function and purpose of the GMC's FTP procedures.

18.236 I shall revert to these issues again in later Chapters, when discussing problems that have been detected in the operation of the later stages of the GMC's conduct procedures. Their relevance, in case the reader is in doubt, is to the important question of whether the GMC will in fact bring a new approach and attitude to the new procedures or whether, like the leopard, it will be unable to change its spots.