

Council

4 December 2000

GENERAL
MEDICAL
COUNCIL

*Protecting patients,
guiding doctors*

3a

To note

The Outcome of the Consultation about the Structure, Constitution and Governance of the GMC

Issue

1. The main points arising from the consultation on the Governance Working Group's proposals.

Recommendation

2. To note this report (paragraph14).

Further information

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Background

Distribution of the consultation document

1. Following the Internal Conference on 18 September 2000 the consultation document was launched at a press briefing on 11 October 2000.
2. Copies of the document were initially sent to 670 organisations. During the consultation period approximately 120 further copies were requested and distributed, mostly to organisations.
3. The document was available on the GMC's website. The document was downloaded 276 times.

Replies received

4. The consultation period formally finished on 15 November 2000. We received 126 replies to the consultation document by 22 November 2000, and they are included in this analysis. A list of the organisations that responded is at Annex A.

Number of replies

5. The following table breaks down the total number of responses received.

	Medical	Lay	Other ¹	Total
Individuals	7	4		11
Organisations	65	31	19	114
Grand Total				126

1. 'Other' includes responses that could not be categorised as medical or lay, for example government departments and private healthcare providers.

Nature of the report

6. This report is a summary of the replies received. The originals are available to members on request.
7. The great majority of contributions are from organisations. In the tables below, the number individual responses included in a figure is shown in brackets.
8. We have quoted from some contribution but have generally not attributed comments.

Quality assurance

9. Following the approach adopted in the Revalidation project, we invited members from outside the Governance Working Group to quality assure this report. Dr Malcolm Lewis and Mr Roland Doven agreed to act as the quality assurance assessors. They investigated:

- a. The representation of the comments from respondents' within the database.
 - b. The representation of that information within this report.
10. Their report is at Annex B.

Discussion

11. This report follows the structure of the consultation document by analysing views on the five broad options outlined by the Governance Working Group, followed by responses to the consultation questions.

The Options

12. The GWG explored five options, with Option E as the Group's preferred model. The consultation paper did not invite respondents to indicate their preferred option, if any, and, in retrospect, it might have been useful to have provided a question which would have invited for clear responses. There were 23 respondents who clearly identified a preferred option, illustrated by the following table:

Preferred Option	Medical	Lay	Other	Total
Option A			1	1
Option B	1		1	2
Option C	1	1		2
Option D				
Option E	15	3		18

The consultation questions: headline responses

13. The headline responses to each consultation question were:

Question 1: Do you agree with our analysis of the principles?

The majority of responses agreed with the GWG's analysis.

Question 2: What are your views on how Parliamentary scrutiny of our work could be developed?

Most respondents identified the Health Select Committee; or similar all-party committee structures.

Question 3: How can co-operation with Government best be achieved?

There were few specific ideas beyond acknowledging the need for regular and open dialogue.

Question 4: What should the GMC's links be with the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly?

Respondents accepted the need for strong links, but stressed the UK-wide nature of the GMC's work.

Question 5: Do you agree with our analysis of the five broad options?

There was a high level of agreement with the analysis.

Question 6: What are your views on the role of the Board?

There was general agreement with the role proposed in the consultation document.

Question 7: What are your views on the size of the Board? Is 15 too small? Is 25 too large?

There was a general view that 15 is too small.

Question 8: Are three-year renewable terms appropriate for Board members?

Three year renewable terms were generally supported.

Question 9: Should there be a two-term limit on members' service (extendable to three for senior office holders)?

Generally supported; there was less support for an exception for senior officers.

Question 10: Is the proposed balance of lay and medical membership of the Board right?

Most medical respondents indicate that 33%-40% lay membership would be acceptable. Lay respondents tended to 40-50%.

Question 11: Should membership of the Board be conditional upon a minimum attendance commitment? If so, what might this commitment be?

A minimum commitment was very strongly supported. Responses tended to suggest between a 75% and 80% minimum attendance record.

Question 12: What are your views on the appointment and function of the President?

There was a good deal of support for the President's remit as outlined in the document, but the main issue raised under this question was whether the Board or the Conference should appoint the President.

Question 13: Do you agree that the President should be a doctor?

This was generally supported across all respondents, with particularly strong support from medical respondents.

Question 14: Should the President be elected by the Board or the Conference?

Responses were divided on this question.

Question 15: Is a three-year renewable term appropriate for the President?

There was general support for a three year renewable term.

Question 16: Should there be a two-term limit on the President's term of office?

There was generally support for a two year limit.

Question 17: What are your views on the proposed role of the GMC Conference?

The key issue for clarification is whether the Conference is the ultimate authority within the new structure.

Question 18: What are your views on the size and composition of Conference?

There was concern at the proposed size of the Conference; and therefore its effectiveness; general acceptance of a 50-50 lay/medical membership.

Question 19: How we achieve a more transparent electoral system and a greater engagement on the part of the profession?

There was significant support for regional elections in England.

Question 20: What are your views on how we ensure we retain the expertise currently provided by the appointed members?

Strong views were expressed by educational interests on the need to have systems which ensured that the GMC retained this expertise.

Question 21: How should national issues specific to the existing constituencies of Northern Ireland, Scotland or Wales best be addressed by the new structure?

Representation through geographical constituencies (lay and medical) was widely held to be sufficient.

Question 22: What are your views on our proposal for a transparent appointments process against objective criteria for lay members?

There was high level of support, with suggestions for regionally based appointments.

Question 23: What are your views on our proposal for optional limited co-option?

There was general support for a power to co-opt to the Conference, often extended to committees, but there were some strongly expressed views that the medical members of the Conference should be elected.

Question 24: What are your views on our proposals for the role of the Chair of the Conference?

There was general acceptance of the proposed role. Some respondents queried the proposal to bar the Chair from being a Board member.

Question 25: What are your views on the proposal that the Chair of the Conference should be a lay member?

There was significant support for permitting the Conference to choose 'the best person for the job', lay or medical.

Question 26: What are your views on a three year term, renewable up to six years, for the Chair of Conference?

This was generally supported, with support for the principle that the rules should be the same as for the President.

Question 27: Do you agree that fitness to practise functions should be separated?

Almost universally strongly supported.

Question 28: If so, which functions should be separated, and how?

There was no consensus about whether the GMC should be 'prosecutor' or 'judge', or whether functions should be separated on an agency basis.

Miscellaneous

Several respondents welcomed the paper and complimented the GWG on its work.

A number of miscellaneous comments were offered. Among the more critical comments were the following:

'Little is known, or revealed, about the members of the Working Group which produced the document; little is known about their areas of expertise or

particular interests. The document also gives remarkably little information about the next step in the consultation procedure, merely alluding to further consideration by the GMC on 4 December. It is unclear how the results of the existing consultation process will be analysed or used or what form the discussions on 4 December will take.' (*Medical organisation*)

'We are strongly of the view that the paper does not emphasise enough the need to protect patients. The people of this country are surely your prime stakeholders and it is felt that if this is not more positively recognised and articulated by the GMC, public confidence may not be restored.' (*Private health provider*)

A professional body commented that the GMC should have been exposed to the kind of external review that had taken place for the UKCC and CPSM; and three non-medical organisations expressed concern that the proposals diverged from those for the UKCC and CPSM successors.

Several respondents commented that issues around process and function needed to be resolved before making changes to structure.

Some LMCs and other respondents commented that the criminal standard of proof should be preserved in fitness to practise. LMCs, professional bodies and the defence organisations commented on the need to speed up FTP procedures.

There were a few comments about the short time allowed for consultation, and that the typeface used in the document was difficult to read.

Summary of responses

14. On the following pages we summarise the responses to each question. Where we indicate the level of agreement in response to a question we mean support among those who responded to that question, not of respondents overall. Those agreeing with a proposal tended to do so in one word; those disagreeing often explained their reasoning. There is little evidence of clear-cut lay/medical divides on any issue.

Recommendation: To note this report.

Resource implications

15. None from this paper.

Question 1

Do you agree with our analysis of the principles?

Number agreeing

Medical	Lay	Total
37(5)	14	55

Number disagreeing

Medical	Lay	Total
3	0	5

The figure in brackets indicates the number of responses from individuals included.

The total includes responses that could not be categorised as medical or lay. These include bodies such as private healthcare providers and government departments.

Summary

There was significant agreement with the analysis. Several comments were along the lines that the analysis was 'fair' 'sound' or 'sensible.'

Some respondents suggested additional principles: 'democracy'; 'affordability'; 'independence'; 'transparency'; 'efficiency'; others wanted to put greater emphasis on 'accountability'.

Some educational bodies were disappointed that there was not a clearer discussion about the GMC's educational role, and how this interfaced with the roles of the Royal Colleges, the Medical Education Standards Board and others. There were two comments that the analysis did not encompass continuing professional development.

A consumer body was concerned that the GMC was overly influenced by concern for professional inclusivity.

One medical representative body expressed a strong view that structure was not the problem; the key requirements were for clarity, focus, democracy and leadership.

One LMC felt that the appraisal was fundamentally flawed, and suggested that the 'interrelated' elements of standards, education, registration and fitness to practise should be divided into separate entities.

Question 2

What are your views on how Parliamentary scrutiny of our work could be developed?

Number commenting

Medical	Lay	Total
33 (5)	16	58

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

Many respondents identified the Health Select Committee or a similar standing committee as the appropriate mechanism. Some responses under Q3 also referred to all-party committees. Among the comments were:

- a. 'The Privy Council is an archaic body, little known and little understood. It would be better if the GMC had a formal relationship with the Health Select Committee.' (*National patients organisation*).
- b. 'The GMC, like the Ombudsman, should submit a report on fitness to practise cases to Parliament'. (*National lay organisation*).
- c. 'It is right that Parliament should settle structures and processes and monitor and challenge'. (*Medical defence organisation*).

There were some contrary views:

- d. 'Following the spirit and the letter' of the Human Rights Act, it would be inappropriate for the body which grants the GMC's powers to be responsible for its scrutiny and audit: an independent body should scrutinise the GMC and make recommendations to Parliament.' (*Medical defence organisation*).

A few respondents asked whether the proposed UK Council for Health Regulators would provide a reporting mechanism for the GMC.

Question 3

How can co-operation with Government best be achieved?

Number commenting

Medical	Lay	Total
32 (5)	12	54

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

Close links and regular dialogue were strongly supported, qualified by the need for the GMC to remain independent. Some respondents asked under this question about the GMC's relationship with the proposed UK Council for Health Regulators.

Suggestions included

- a. 'An all-party working group whose role it would be to establish close links on behalf of the Government with the GMC.' (*medical defence body*).
- b. A Forum including the Presidents/Chairs of the regulatory bodies, CHI, Care Standards Commission, senior Department officials, CMO, CNO and occasionally Ministers. (*Private healthcare provider*).
- c. Inviting the Chief Medical Officer and/or the NHS Chief Executive to be ex-officio members of the GMC Board. (*Royal College*).

Some respondents bristled at the notion of 'co-operation' with Government.

Question 4

What should the GMC's links be with the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly?

Number commenting

Medical	Lay	Total
28 (4)	13	54

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

Many respondents commented that the GMC needed to maintain a strong dialogue with devolved administrations. There were no clear steers on the mechanism for this. We received positive feedback from the health departments:

- a. 'We feel that it is important that the GMC continues to recognise its UK-wide remit and the need to liaise with the relevant health departments.' (*NI DHSS*)
- b. 'We welcome the importance that the Council attaches to the need for good communications with the National Assembly for Wales and the other devolved administrations. We are keen to offer the Council every assistance.' (*National Assembly for Wales*).
- c. 'At an administrative level, there are already meetings between officials ...and the GMC...and we would wish these to continue.' (*Scottish Executive Health Department*).

There was significant emphasis on our UK wide remit and on the fact that the standards which we apply are UK-wide, as summed up in the following comment:

- d. 'Professional standards do not depend upon where a doctor or patient resides' (*LMC*).

One lay body wanted to see some regulatory functions devolved to a regional level.

Question 5

Do you agree with our analysis of the five broad options?

Number agreeing

Medical	Lay	Total
31 (4)	13 (1)	49

Number disagreeing

Medical	Lay	Total
6 (1)	2	12

The totals includes responses that could not be categorised as medical or lay.
The figures in brackets indicates the number of responses from individuals included.

Summary

Many respondents agreed with the analysis, without expressing a preference for one of the options.

'Members felt that this section was well analysed and presented' (*CHC*)

Some of those who disagreed preferred the model proposed for the UKCC and CPSM successors. Another comment was:

'We are not convinced that the preferred option E of a small Board and a large Conference can fulfil the principles of effectiveness, inclusiveness and accountability, established at the outset, or that this model is a logical consequence of the required functions. The document does not give a fair and detailed analysis of the positive and negative elements of the other options.' (*medical representative body*)

Question 6

What are your views on the role of the Board?

Number commenting

Medical	Lay	Total
39 (4)	16	67

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

The roles outlined in paragraph 80 of the consultation document received significant support. Some suggested that while the Board's role was broadly acceptable, it should be answerable to the Conference; others commented on the practical need for the Board to delegate.

Comments included:

- a. The Board should hold the statutory powers 'but that the important powers granted by Parliament and currently vested in the Education Committee should be preserved, so that an Education Committee should continue.' (*Royal Colleges*)
- b. The Board's role should include the strategic management of all racial equality considerations. (*Commission for Racial Equality*).

Question 7

What are your views on the size of the Board? Is 15 too small? Is 25 too large?

Number saying 15 too small

Medical	Lay	Total
20 (4)	10	33

Number saying 25 too large

Medical	Lay	Total
14 (2)	3	18

The figures in brackets indicates the number of responses from individuals included.
The totals include responses that could not be categorised as medical or lay.

Summary

The general view was that 15 was too small; a few thought that 25 was acceptable, others that this was too large. These were not mutually exclusive options: '15 is too small; 25 is too large' (*LMC*). There was some support for the range of 20-25 members. Some respondents commented that there was no magic figure, and that competency was what mattered.

Those in favour of a smaller Board tended to comment on the effectiveness of small bodies; those in favour of a larger Board, and particularly medical representative bodies, expressed concerns about achieving diversity of representation. Among the comments made:

- a. 'The Board as proposed is too small to be properly representative of the profession'. (*medical organisation*).
- b. 'To be honest, credibility among GPs would be nil if no GP was on a Board responsible for initiating and defining policy and strategy' (*LMC*).
- c. 'To promote inclusivity, the various tiers of governance should reflect the ethnic diversity of the GMC membership. In those circumstances where the size of any tier is too small to facilitate adequate numerical representation, then it would be appropriate to co-opt at least one ethnic minority member to its composition.' (*CRE*)

Some medical school respondents commented on their experiences with small Boards and larger University 'Courts'.

Question 8

Are three-year renewable terms appropriate for Board members?

Number agreeing

Medical	Lay	Total
35 (4)	9	47

Number disagreeing

Medical	Lay	Total
3	2	4

The figure in brackets indicates the number of responses from individuals included.
The totals include responses that could not be categorised as medical or lay.

Summary

Very widely supported; one LMC and a postgraduate dean suggested four year renewable terms; others noted that the proposal in the governments plans for the successors to the UKCC and CPSM were for four year terms.

'Longer terms (say 4 or 5 years) would be better. For GPs in particular, there would need to be considerable restructuring at practice level and two such changes in 3 years could be destabilising.' (LMC)

Question 9

Should there be a two-term limit on members' service (extendable to three for senior office holders)?

Number saying yes to two-term limit

Medical	Lay	Total
31(2)	12	47

Number saying no

Medical	Lay	Total
2	1	3

The figure in brackets indicates the number of responses from individuals included.
The totals include responses that could not be categorised as medical or lay.

Summary

Two-term limits for members were almost universally supported among those who responded to this question; several respondents who agreed with a two-term limit felt that the limit should apply to senior officers as well:

'What is a 'senior officer holder' and what is the justification for allowing them three periods of office?' (*Faculty*).

Question 10

Is the proposed balance of lay and medical membership of the Board right?

Number saying yes

Medical	Lay	Total
23 (1)	4	28

Number saying no

Medical	Lay	Total
8 (1)	14	27

The figures in brackets indicates the number of responses from individuals included.
The totals include responses that could not be categorised as medical or lay.

Summary

Medical respondents tended to indicate that 33-40% lay membership would be appropriate, lay bodies tended to support 40% -50% membership.

Comments included

- a. 'Any seat on the Board for the Chief Executive should count as one of the lay seats.' (*Royal College*).
- b. The composition of the Board should match that of the Boards for the successors to the UKCC and CPSM: 12 registrants and 11 lay members (*non-medical professional organisations*).

Question 11

Should membership of the Board be conditional upon a minimum attendance commitment? If so, what might this commitment be?

Number saying yes

Medical	Lay	Total
26 (3)	18	50

Number saying no

Medical	Lay	Total
0	0	0

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

There was very strong support for a minimum commitment – no-one opposed the proposal, although some thought it needed further consideration. Support for minimum commitments ranged from specifying 50%, 66%, 75% or 80% of meetings, but support was mainly for a 75%-80% attendance requirement. Other suggestions were that membership should cease after missing consecutive meetings.

The issue of payment to members was raised, with an individual respondent querying whether payment of a 'salary' beyond reimbursement of expenses might affect Board members' relationship with the organisation.

It was suggested that Board members' attendance records should be published annually.

It was suggested that there may need to be statutory authority for employers to provide time off.

Question 12

What are your views on the appointment and function of the President?

Number commenting

Medical	Lay	Total
33 (5)	21	64

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

There was widespread support for the President's remit, but the main issue raised under this question was whether the President should be appointed by the Board or the Conference, with several lay and medical respondents suggesting that the Conference should appoint (see Q14).

Some medical respondents queried the proposed role of 'leadership' for the medical profession, suggesting that there were others who provided this leadership.

Question 13

Do you agree that the President should be a doctor?

Number agreeing

Medical	Lay	Total
36 (6)	14	60

Number disagreeing

Medical	Lay	Total
9	6 (1)	15

The total includes responses that could not be categorised as medical or lay.
The figures in brackets indicate the number of responses from individuals included

Summary

Most medical respondents and a high proportion of lay respondents agreed that the President should be a doctor.

A small number of respondents said that the President should be the best person for the job, medical or lay. One comment was that if the President was a doctor, the Chief Executive should be lay.

Question 14

Should the President be elected by the Board or the Conference?

Number saying Board

Medical	Lay	Total
15(2)	7	28

Number saying Conference

Medical	Lay	Total
21 (3)	14	40

The totals includes responses that could not be categorised as medical or lay.
The figures in brackets indicate the number of responses from individuals included.

Summary

There was divided opinion on this point, with no obvious lay/medical divergence.

Points made in favour of election by the Conference were greater transparency and democracy; others said that the President should be elected by the Board because this was the body which he or she would chair. Variations included a proposal made by the Board and subject to ratification by Conference; Conference having the right to remove the President if he or she was not performing; and two individual respondents suggested that there should be a national election (within the profession) for the President.

Two organisations suggested external appointment of the President.

Question 15

Is a three-year renewable term appropriate for the President?

Number saying yes

Medical	Lay	Total
32 (4)	13	50

Number saying no

Medical	Lay	Total
5	1	6

The figure in brackets indicates the number of responses from individuals included.
The totals includes responses that could not be categorised as medical or lay.

Summary

Very widely supported.

There were a few other suggestions (four year terms; or a three year non-renewable term, or only renewable for one year). Where comments were added to 'yes' responses they tended to say that it made sense for the President's term of office to match that of Board members.

Question 16

Should there be a two-term limit on the President's term of office?

Number saying yes

Medical	Lay	Total
27 (1)	9	43

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Number saying no

Medical	Lay	Total
5(1)	0	5

Summary

There was overwhelming support for a two-term limit. Of those who disagreed, one LMC and one Royal College wanted a single term limit. There were two suggestions for an upper age limit, one suggesting 70 years; and a question whether the President's terms should be counted separately from any terms previously served as a Board member.

Question 17

What are your views on the proposed role of the GMC Conference?

Number commenting

Medical	Lay	Total
35 (3)	15 (1)	61

The total includes responses that could not be categorised as medical or lay.
The figures in brackets indicate the number of responses from individuals included.

Summary

The general support for the proposed role is qualified by a number of comments about the Conference's authority, which tie in with comments made in support of the Conference electing the President. For example: 'the Conference must ultimately be accountable for the actions and performance of the GMC' (*individual doctor*); 'We believe that the Board should be accountable to Conference (LMC); 'The Conference should have the right to...discharge the Board if they are not fulfilling the objectives of the Conference' (LMC); 'the Conference has largely a steering role but...nevertheless accepts the ultimate responsibility.' (*Royal College*).

Another comment was that the introduction of a Standing Conference which elects a Board was 'a muddle': 'We have concerns about creating a Standing Conference with no statutory authority but which because of its responsibility for election of members to the Board could wield a significant amount of power and influence.' (*lay organisation*).

Some organisations queried the need for a Conference: two on the basis that the Government's proposals for successors to the UKCC (with over 600 000 registrants) and the CPSM (with 120 000) envisage Boards of 23 members, without a second tier.

Respondents' reservations were usually around the frequency of meetings ('A body which only meets twice a year will achieve little' LMC); and that the Conference should meet at different venues around the UK.

Four respondents suggested that the Board's medical members should be elected from the whole profession.

Question 18

What are your views on the size and composition of Conference?

Number commenting

Medical	Lay	Total
36 (3)	19 (1)	64

The total includes responses that could not be categorised as medical or lay.
The figures in brackets indicate the number of responses from individuals included.

Summary

Comments tended to focus on whether 150 was too large a body to be effective; some suggested that 120 was the maximum. There was general acceptance of a 50-50 lay/medical membership.

The *CRE* wrote that all tiers of governance should ensure that race equality expertise is available from among their membership.

A medical defence organisation was not sure that the Conference, even with 200 members, would be large enough to provide members for GMC committees and for FTP panels, and could see virtue in adding co-options to committees or to the Conference itself to boost the overall size of the Conference.

Age Concern commented 'We urge the GMC not to set any upper age limits for members of the Conference, as are currently set (at age 70) for Council members' on the grounds that more people over the age of 65 access health services than any other section of the population, and as the largest group of users they form one of the most important groups of stakeholders.

There were a few comments that the title 'Conference' was not right: 'I am a little surprised that the so-called Conference should not remain under the title Council if that is to be the final legal body for the GMC' ; ' We would prefer Council of Advisers'; 'I would urge that the proposed 'Conference' be replaced by a 'Council', so reflecting its authority and functions.' (*lay individual*).

Question 19

What are your views on how we achieve a more transparent electoral system and a greater engagement on the part of the profession?

Number commenting

Medical	Lay	Total
37 (3)	14	60

The figure in brackets indicates the number of responses from individuals included.
The total includes responses that could not be categorised as medical or lay.

Summary

There was considerable criticism of the current electoral arrangements, and wide support for regionally based elections.

There were two comments that perhaps there could be some random filled places from the profession for those randomly selected.

One suggestion that a proportion of Conference members should be subject to re-election each year.

Question 20

What are your views on how we ensure we retain the expertise currently provided by the appointed members?

Number commenting

Medical	Lay	Total
41 (4)	12	63

The figure in brackets indicates the number of responses from individuals included.
The total includes responses that could not be categorised as medical or lay.

Summary

This question evoked strong responses:

- a. 'We are gravely concerned at the proposal that the medical membership of the Standing Conference should be determined entirely by election...the Royal Colleges in general have a record of working alongside the GMC...we feel that in recent years this partnership has been taken for granted and consistently undervalued by the GMC.' (*Royal College*)
- b. It should not be left to elections to secure the expertise that is needed. As a College Council is democratically elected by its members, a Council appointment to the GMC is not undemocratic. (*Royal College*)
- c. The GWG has failed to make a case for removing the right of medical Royal Colleges and Faculties and the universities with medical schools to appoint medical members, as they have done since 1858. If lay members are to be appointed it is 'intellectually inconsistent' to deny appointing some doctors to the Board as well. (*Royal College*)
- d. 'The power of large voting groups would lead to smaller professional groups being disenfranchised: the system of appointments should therefore continue.' (*Faculty*).

There were contrary views that all medical members should be elected. Other comments were:

- e. 'One of the criticisms of the GMC has been around the number of longstanding appointed members' (*non-medical organisation*).
- f. 'We are unhappy with the current arrangement whereby a large proportion of the GMC is made up of members appointed by the medical Royal Colleges' (*medical organisation*).

Various views were offered about process, including protected electoral seats, perhaps with a separate electoral constituency for academic members, and co-options.

Question 21

How should national issues specific to the existing constituencies of Northern Ireland, Scotland or Wales best be addressed by the new structure?

Number commenting

Medical	Lay	Total
24 (4)	10	41

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

There were some doubts about the extent of devolved issues. The *Northern Ireland DHSS* commented that it was not aware of any national issues specific to Scotland, Wales or Northern Ireland: 'the standards set by the GMC and the processes put in place are equally applicable irrespective of geographic location. Issues of representation can be dealt with on a geographical constituency basis.'

Geographically-linked representation (of both lay and medical members) was sufficient for most respondents. The responses to this question can be compared with question 4.

One suggestion for there to be offices in each country, shared with other health regulators.

Question 22

What are your views on our proposal for a transparent appointments process against objective criteria for lay members?

Number commenting

Medical	Lay	Total
31 (4)	18	59

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

There was support for locally advertised regional appointments (which were not floated in the consultation paper); reasons given for this included: 'Is there any merit in some geographic spread for the lay members or are we paranoid in the north that the GMC is London/South top heavy?' (LMC)

Mencap commented that lay membership should include disabled people with chronic conditions and people with experience of those with severe learning difficulties, mental illness or dementia.

Some respondents for a clearer definition of 'lay' – one comment was that the public perception of healthcare managers is that they are not 'lay'.

Other comments: that there is a need for clear criteria for appointment/election of all members; the process should allow for nominations by stakeholders in addition to self-nomination; medical members could be appointed along the same lines.

Question 23

What are your views on our proposal for optional limited co-option?

Number commenting

Medical	Lay	Total
33 (4)	13	56

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

Few respondents simply agreed with the proposal. Comments included: co-options should deal with specific issues, not to create additional members; ultimate decisions on co-option should be taken by the Conference, not a co-options committee; co-options should be kept to a minimum; all committees should have the power to co-opt; if the Conference is constructed around constituencies, there should be no great need for co-options;

‘To promote inclusivity, the various tiers of governance should reflect the ethnic diversity of the GMC membership. In those circumstances where the size of any tier is too small to facilitate adequate numerical representation, then it would be appropriate to co-opt at least one ethnic minority member to its composition.’
(*Commission for Racial Equality*).

Question 24

What are your views on our proposals for the role of the Chair of the Conference?

Number commenting

Medical	Lay	Total
30 (4)	13	52

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

There was significant support for the role outlined in the paper, but several respondents had doubts about the Chair not being a member of the Board – for example, ‘That gives the wrong message to the Conference about where the real power lays.’ (*LMC*); ‘I am not entirely clear why the Chair of Conference cannot be a member of the Board.’ (*University*)

Question 25

What are your views on the proposal that the Chair of the Conference should be a lay member?

Number commenting

Medical	Lay	Total
37 (5)	17 (1)	61

Number supporting lay Chair as proposed

Medical	Lay	Total
13 (3)	8	22

The figures in brackets indicate the number of responses from individuals included.
The total includes responses that could not be categorised as medical or lay.

Summary

There was support for a lay Chair, but there was also significant support for allowing the Conference to choose 'the best person for the job'. This came equally from medical and lay respondents, several of whom support the principle that the President should be a doctor.

One comment was that the President should not necessarily be barred from being Conference Chairman.

Question 26

What are your views on a three year term, renewable up to six years, for the Chair of Conference?

Number commenting

Medical	Lay	Total
30 (3)	14	51

Number agreeing with a three year renewable term

Medical	Lay	Total
16 (3)	10	29

The total includes responses that could not be categorised as medical or lay.
The figures in brackets indicate the number of responses from individuals included.

Summary

There was general support for this, including several comments that the same terms should apply to the Chair as apply to the President, for example:

'The entire model can only work if the terms of office for the President, Chair of Conference and members of the Board and the Conference are the same.' (LMC)

Where there was disagreement, this tended to be around the provision for a second term. There was some support for four year terms; and a suggestion that the age limit of 70 years should be retained.

Question 27

Do you agree that fitness to practise functions should be separated?

Number agreeing

Medical	Lay	Total
39 (3)	15	64

Number disagreeing

Medical	Lay	Total
1	0	1

The totals include responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

With the exception of a specialist society, all who responded to this question supported the separation of functions, often very strongly.

Question 28

If so, which functions should be separated, and how?

Number commenting

Medical	Lay	Total
37 (4)	16 (1)	62

The total includes responses that could not be categorised as medical or lay.
The figure in brackets indicates the number of responses from individuals included.

Summary

There was an even split of views within medical and lay respondents on whether the GMC should be responsible for the 'prosecuting' or 'case-determining' function. There were also differences of view about how much distance there should be between the separated function and the function regarded as the core GMC function.

Several respondents chose to reserve judgment until after a fuller debate of the issues, with some asking whether separate arrangements were required for conduct, performance and health.

It was suggested that we look additionally at a third option not presented in the paper under which both the 'prosecuting' and 'case-determining' functions would be separated. The arrangements for the regulation of solicitors provide a model for this option: the Law Society is responsible for registration, policy, standards and education, the Office for Supervision of Solicitors for complaint handling and the 'prosecuting' function and the Solicitors Disciplinary Tribunal for the 'case-determining' function.

Annex A

Organisations which responded

Academy of Medical Royal Colleges
Academy of Medical Sciences
Age Concern
Alexander Harris solicitors
Association of Anaesthetists of Great Britain and Ireland
Association of Community Health Councils for England and Wales (ACHCEW)
Ayrshire and Arran Health Council
Basildon Brentwood and Thurrock CHC
Beachcroft Wansbroughs
Blackpool, Wyre and Fylde CHC
Bradford LMC
Brent and Harrow LMC
British Association of Dermatologists
British Association of Medical Managers
British Association for Paediatric Nephrology
British Association of Plastic Surgeons
British Medical Association
British Orthopaedic Association
British Society for Rheumatology
Bromley LMC
Bro Taf LMC
BUPA
Cambridge CHC
Cambridgeshire LMC
Carmarthen CHC
Central Committee for Hospital Dental Services
Chichester CHC
Commission for Racial Equality
Committee of General Practice education directors (COGPED)
Committee of Vice-Chancellors and Principals (CVCP)
Conference of Postgraduate Medical Deans (COPMED)
Consortia of LMCs
Consumers Association
Conwy CHCs
Department of Health, Social Services and Public Safety (Northern Ireland)
Derbyshire LMCs
Doncaster LMC
East Dorset CHC
East Herts CHC
East Sussex LMC
East Yorkshire CHC
Enfield and Haringey LMC
Faculty of Occupational Medicine

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Faculty of Public Health Medicine
Gay and Lesbian Association of Doctors and Dentists
Great Yarmouth and Waveney CHC
Gwent CHC
Harrogate and District CHC
Health Communication Network
Hospital Consultants and Specialists Association
Huntingdon CHC
Independent Healthcare Association
Institute of Healthcare Management
Joint Committee for Higher Surgical Training
Joint Consultants Committee
King's College London
Liverpool LMC
Lothian LMC
Macclesfield CHC
Medical Association of Nigerian Doctors and GPs (MANSAG)
Medical Defence Union
Medical and Dental Defence Union of Scotland
Medical Protection Society
Mencap
Mid-Surrey CHC
National Assembly for Wales
National Association of GP Tutors
National Childbirth Trust
Newcastle CHC
North Cheshire Local Medical Committee
North East Scotland Faculty of RCGP
North Staffordshire CHC
North Tyneside CHC
North West Anglia CHC
Northern Ireland Department of Health, Social Services and Public Safety
Norwich and District CHC
Overseas Doctors' Association
Patient Concern
PPP Healthcare
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Pathologists
Royal College of Paediatrics and Child Health
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal Institute of Public Health and Hygiene
Royal Pharmaceutical Society of Great Britain
Salford and Trafford LMC

EMBARGOED UNTIL 10:00AM MONDAY 4 DECEMBER 2000

Scarborough and North East Yorkshire CHC
Scottish Council for Postgraduate Medical and Dental Education
Scottish Executive Health Department
Scottish Joint Consultants Committee
South Durham and Weardale CHC
South Tees CHC
South Thames Postgraduate Medical and Dental Education
St Bartholomew's and The Royal London School of Medicine and Dentistry
St Helens and Knowsley LMC
Suffolk LMC
United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).
University of Bristol Medical School
University of Cambridge School of Medicine
University of Dundee Medical School
University of Oxford Medical School
University of Sheffield School of Medicine
University of Wales College of Medicine
Wakefield LMC
Wandsworth Community Health Council
Wirral LMC
Women in Medicine
Worcestershire LMC
Worshipful Society of Apothecaries
York, Tadcaster and Selby CHC

Annex B

The Outcome of the Structure, Constitution and Governance Consultation Exercise: Quality Assurance Report.

In order to separate the functions of the Office in preparing the report on the outcome of the Structure, Constitution and Governance consultation exercise, and the Governance Working Group (GWG) in considering the report prior to presentation to Council, it was decided that a quality assurance process should be carried out by individuals who were, and remain, external to the GWG and the responsible office staff.

A lay member, Mr Roland Doven, and a medical member, Dr Malcolm Lewis, were approached with a view to carrying out this process of quality assurance. Both (herein the QA assessors) agreed to undertake the task.

The report to Council is based on over 100 responses to the consultation document. The responses have been loaded onto a Microsoft Access database. Within the database the responses are categorised according to 34 areas of response. The areas of response represent the 28 questions, the five options and a section for miscellaneous comments. Cross-referencing to categories of respondent is easily achieved within the database. The pattern of response of each 'individual' may also be easily followed within the database.

The database should contain the relevant information that informs the report to Council. The source of information prior to its database entry is the 100+ responses from the profession, laity and 'corporate' or 'representative' bodies and organisations. A list of organisational responses is annexed to the report (Annex A). The vast majority of responses came from lay and professional organisations with only a handful of responses from individuals.

From the 100+ responses, the database has been loaded with a total of 1438 entries, each of which may represent several comments. These comments, or at least the themes they project, should be represented in the body of the report to Council.

In addressing the issue of quality assurance the QA assessors felt that the information on the database should reflect, as closely as possible, the comments given in written responses, by those 100+ parties that have contributed to the exercise. Furthermore, the report to Council must accurately represent the information on the database, and thus the original comments of the contributors. There are therefore two phases to the quality assurance exercise:

1. The representation of the comments from the letters of individual respondents (or organisations) within the database.
2. The representation of the information on the database within the body of the report to Council.

Observations.

Phase one

The assessors worked together at the GMC offices at Great Portland Street. Both assessors read the responses and compared these to the database entries. All responses were assessed and compared to the corresponding database entry. There were no serious omissions of comments made by the respondents. The QA assessors were very impressed by the detail and quality of the entries on the database, as compared to the original responses. Where an omission occurred (which was very rare), this was thought to be of no significance and no key points were missed in the transposition of information from the responses to the database.

Conclusion

The database accurately reflects the responses received by the GMC to the Structure, Constitution and Governance consultation paper.

Phase two

One assessor read 1438 (100%) of the database entries based on responses received by the end of 21 November 2000, and compared the entries with the comments made in a draft of the report to Council on the Outcome of the Consultation on Structure, Constitution and Governance.

On completing this exercise, the assessor was confident that the report accurately reflected the comments in the database and there was no bias of interpretation in any of the categories or questions listed in the report.

We understand that further responses received on 22-23 November 2000 will be incorporated into the database and in the final version of the report which will be sent to Council.

Conclusion

The report on the Structure, Constitution and Governance Consultation Exercise accurately reflects the information stored on the database.

Summary

The assessors are confident that both phases of the QA exercise have revealed that the report accurately represents the responses received to the GMC's consultation document.

Malcolm Lewis and Roland Doven
23 November 2000