# Academy of Medical Royal Colleges

## Response to the Consultation Document

## *Good doctors, safer patients*

*Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*

*A report by the Chief Medical Officer*

November 2006

# Response to the Consultation Document

## *Good doctors, safer patients*

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**ACADEMY OF MEDICAL ROYAL COLLEGES**

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## Summary


- The Academy affirms its commitment to the chief principles surmounting the recommendations of *Good doctors, safer patients* - the need to protect patients and establish fair and effective fitness to practice procedures, and the establishment of revalidation through re-licensing and re-certification. Our response to the consultation rests on judgements about the best ways of achieving these aims.

- The Academy shares the aspiration of *Good doctors, safer patients* that 'patients, the public, the medical profession, employers and other contracting organisations become able to trust that every doctor will deliver good clinical care throughout their careers'.

- With certain reservations the Academy believes the approach offered in Good doctors, safer patients represents a significant move towards raising standards and improving regulation. We particularly welcome the observation that a degree of professional 'ownership' of regulation can be regarded as a defining feature of professionalism and is essential to engagement.

- The Academy is able to give broad, but not always unqualified support to the recommendations of *Good doctors, safer patients*. Some have roused particularly vigorous discussion and concern. They call for a more searching exploration of the evidence underpinning them than the consultation document allows, as do the organisational implications and the resources necessary for implementation.

- As *Good doctors, safer patients* recognises, implementation of new regulatory processes must take account of the different statutory and organisational arrangements between the countries of the UK.

- We see the need for a great deal of work in order to ensure that the mechanisms put in place can achieve the reforms sought, albeit with the least possible delay.

- It is our view that reforms already made by the GMC and the expertise it harbours are not sufficiently acknowledged, and we see them as important to build on. We have a concern too that the proposals bring a risk of fragmenting regulatory responsibilities and the accountability that goes with them.



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## Background

The Academy brings together the Presidents and Chairmen of all the Medical Royal Colleges and Faculties in the UK and Ireland. It aims to promote close collaboration of these independent institutions and to bring a unified view to issues that should be addressed to improve health and the quality of patient care.

This document gives the collective response of the Academy to *Good doctors, safer patients*. The constituent bodies have made comprehensive responses, supplemented by responses from their Training Committees. So too has the Patient/Lay Committee of the Academy (which comprises the lay chairmen of patient liaison groups within Colleges and Faculties). The range of opinion and comment expressed in those responses has informed the preparation of this statement (see Appendix).

### *Good doctors, safer patients*

*Good doctors, safer patients* has a sole and unifying aim – to improve the quality and safety of medical care in the United Kingdom. Important underlying objectives include:

- Promoting and assuring good practice, whilst also protecting patients from bad practice;
- Increasing public and professional confidence in the GMC and its procedures;
- Narrowing the regulatory gap between the GMC (as statutory regulator) and those who employ or contract with doctors.

The Recommendations are ordered among four themes. They provide a natural arrangement for this response, both for ease of reference and to aid scrutiny and analysis. They are:

- Recommendations to ensure effective and fair fitness to practice procedures;
- Recommendations to assure and improve the quality of medical practice;
- Recommendations to address the need for better information for the public, employers and professional bodies;
- Recommendations to address the structure and governance of the GMC.

Most of the recommendations have also been classified across 12 key areas (see below, taken from the accompanying document Initial Regulatory Impact Assessment, *Good doctors, safer patients*). This offers a sharper focus. The areas are:

- Governance and accountability of the General Medical Council;
- Introduction of a defined set of standards and their incorporation into doctors' contracts;
- Adoption of the Civil standard of proof in relation to fitness to practise matters;
- Devolution of specified General Medical Council powers to a network of accredited General Medical Council Associates and their teams;
- Creation of a new Independent Tribunal to adjudicate in certain fitness to practise matters;
- Provision for the central GMC to resolve specified fitness to practise issues consensually, with an increased focus upon rehabilitation where deemed appropriate;
- Creation of a revised form of 'revalidation', consisting of regular re-licensure for all doctors and intermittent re-certification for those on GP and Specialist registers;
- Changes to the Medical Register and proposals on access to information;
- Revision to the process of assessment where fitness to practise is questioned;
- Transfer of responsibilities for undergraduate education to PMETB;
- Provision of dedicated assessment and treatment services for doctors who are addicted to drugs or alcohol;
- Introduction of English language testing prior to first employment with the National Health Service.


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Recommendations that do not fit into this classification are:

- Formation of a clinical audit advisory group and development of robust national audits (Recommendation 33);
- Research and further discussion around the use of death certification data, prescribing data and other data sources as screening tools in primary care (Recommendation 34);
- Research (financial incentives for safe practice) (Recommendation 37);
- Engaging locum doctors with General Medical Council Affiliates (Associates), licensing locum agencies, and introducing feedback from contracting organisations (Recommendation 25);
- Complaint handling and 'exit interviews' for patients leaving a particular primary care list without changing address (Recommendation 41);
- Consideration of a standardised pre-registration examination for all potential registrants (Recommendation 21);
- Student registration with the General Medical Council and General Medical Council Associates within UK medical schools (Recommendation 23).

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## General view

*Good doctors, safer patients* sets out a clear, full and thoughtful account of the history of regulation of the medical profession, the insistent social and political trends, and a number of revelatory events that have led to this stage in bringing about reform. Following the most recent of these, The Shipman Inquiry, the Secretary of State for Health asked the Chief Medical Officer for England, Sir Liam Donaldson, Chief Medical Officer, 'to undertake a review and report his advice to me on what further measures are necessary to:

- strengthen procedures for ensuring the safety of patients in situations where a doctor's performance or conduct pose a risk to patient safety or the effective functioning of services;
- ensure the operation of an effective system of revalidation;
- modify the role, structure and functions of the General Medical Council'.

The Chief Medical Officer was not asked to consider external factors that influence patient safety or the effectiveness of the service.

Inevitably, the scene is powerfully fixed by the detailed rehearsal of well-known failures to recognise and deal adequately with bad practice and even criminal behaviour up to the mid-1990s. These events have come to overshadow more recent, quite radical changes in the 'landscape' - in respect of quality of care within the NHS, reforms to the constitution and regulatory processes of the GMC, the rigour of medical education and training and continuing professional development, the redefining of medical professionalism, and an increasingly close scrutiny of the performance and conduct of doctors.

Sir Liam observes that there has never been a comprehensive consideration of the core purposes of (medical) regulation, nor of how its different parts should work towards achieving them. We found Chapter 9 of the review - Regulation in the modern world - especially useful, placing medical regulation in this general context and bringing out issues that apply particularly to medical practice.

In the past, most attention has been given to the important task of detecting bad doctors, with much less emphasis on supporting, quality assuring and improving the practice of the vast majority of doctors who already perform to an acceptable standard. Regrettably, as Sir Liam remarks, the needs of doctors with mental illness or those who become alcohol or drug dependent have been neglected.

We are glad that *Good doctors, safer patients* signals a more balanced approach, and we welcome the greater emphasis on maintaining and improving the quality of practice throughout the working life of each doctor, and of restoring fitness to the small minority of doctors who needs might be met by remedial help and rehabilitation.

In areas where the requirement for quality impacts upon safety, regulation has in many spheres been devolved towards the regulated unit, away from central, statutory or governmental regulators. This is reflected in the proposals for local GMC Affiliates. It is an approach that with some reservations we broadly welcome.

We agree there should be regular assessment of doctors' fitness to practise. We agree too that it should be designed to satisfy well-expressed public wishes that it should reach beyond technical skills and include assessment of communication skills, whether or not the doctor is up-to-date, involves patients in treatment decisions and affords them dignity and respect.

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## Detailed Responses to the Recommendations

### Recommendations to ensure effective and fair fitness to practice procedures

#### Standard of proof

(Recommendation 1)

- There is much concern about the standard of proof. Whilst there is acceptance of the need to protect patients in circumstances where a civil standard may be justified, at levels of adjudication where the possible consequences for a doctor are loss of livelihood and reputation the evidence required (which, with robust antecedent processes, should be available) should come close to meeting the criminal standard. (See, for example, the document *Standard of Proof*, prepared by the Royal College of Anaesthetists in response to the consultation).
- For these reasons we cannot support the recommendation as it stands.

#### GMC Affiliates

(Recommendations 2-7,10,15)

- We find much support for increased use of local governance processes, with greater decentralisation of fitness to practise cases, enabling less serious cases to be dealt with promptly but with no less rigour.
- We see these proposals as opening new opportunities to capture closer engagement of doctors in their own regulation.
- The introduction of a new role of GMC Affiliate (referred to as 'Associate' in the Regulatory Annex) could provide one way to facilitate resolution of issues close to the workplace and align regulatory action with that of the employer or contracting organisation. But not all members of the Academy are persuaded that this is the best or only way and many favour giving greater attention to strengthening the processes of clinical governance.
- We wholly agree that members of the public, who have successfully undertaken a programme of training for this purpose, should participate in the regulatory process.
- We agree that an Affiliate should not have the power to impose sanctions affecting registration, a responsibility that should remain with the GMC.

There are further matters, not confined to detail, that call for fuller examination and debate.

- We are sensitive to the heavy responsibility that would fall on a single doctor, however respected and experienced, working with a trained lay person but otherwise isolated. If this approach is pursued we urge consideration of the merits of a larger group – including, say, three doctors – especially in circumstances that call for wider experience or richer deliberation.
- We suggest that consideration be given to the case for a panel of doctors of high standing that, whilst remaining local, is able to serve a wider group of organisations than a single Trust, its members able to find formal support within a larger network.
- Fuller consideration must be given to the ways in which, whilst retaining independent authority and primacy with the public partner in regulatory decisions, an Affiliate would *'operate as part of a wider team within each organisation'*. (See below, also).
- Fuller consideration must be given to the relationship between an Affiliate and the Trust Medial Director and their respective responsibilities and accountabilities in clinical governance.
- Fuller consideration must also be given to the role of the proposed Affiliate in relation to the performance of a doctor in training, the trainer and the Deanery.
- There is a need for fuller consideration of issues surrounding the appointment of such individuals, medical and lay - their training, accountability and assurance of their practice; their relationships within the organisation and with the Colleges;

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their independence, potential conflicts of interest, their impartiality and their consistency in practice.

- It is not at all clear to us how this arrangement might operate. For instance, would the GMC Affiliate make the final decision or would it be arrived at jointly with the lay member? And how might differences be resolved? (See above also).
- We seek fuller detail of involvement of the proposed GMC Affiliates with the Annual Appraisal process and their access to information and evidence discussed at appraisal.
- We seek clarification of the relationship between GMC Affiliates and the Medical Royal Colleges. This would be particularly important for the re-certification element of revalidation. The Colleges would need to have a formal, collaborative relationship with GMC Affiliates to be able to access information necessary for the re-certification of specialty doctors.
- We are concerned to ensure that were the Affiliate to undertake an extension of the GMC's processes into the local place of work, which we would support, it should be made clear that the Affiliate is responsible to the GMC. This may be implied in Recommendations 3 and 10. However, in Recommendation 5 (which states: *Together they should operate as part of a wider team within each organisation. This team should include existing complaints management staff*) and Recommendation 28 (*Necessary information should be collated by the local General Medical Council Affiliate and presented jointly as a confirmatory statement to a statutory clinical governance and patient safety committee by the chief executive officer of the healthcare organisation and the General Medical Council)* there is sufficient to cast doubt on this interpretation.

Recorded concerns.

(Recommendations 3, 4, 6)

- The concept of a 'recorded concern' should be more clearly defined, with a tight framework of practice to ensure a standard approach to its use. All who may be involved in raising such a concern must be sure of the circumstances in which it may be used.
- On the grounds of natural justice as understood in an open society we oppose the recording, however secure, of any information that is hearsay or gossip or has been formally received but not formally assessed. This should include information arising out of a confidential interview with a member of staff from the primary care trust where that information has not been open to formal challenge by the practitioner concerned or the practitioner's representative.
- There is a strong view that a recorded concern should not become a fixed judgment (and an indelible blemish) in nature or duration, but should be capable of becoming 'time–expired'. Indeed a recorded concern should be a stimulus to action, initiating a reasonable period of closer observation and any necessary rehabilitation (see Recommendation 15). Should concerns remain after this time there should be referral to the GMC. If not, the recorded concern should be erased.
- It appears to us that Recommendation 6 signals a lack of confidence in the proposed newly constituted GMC.
- The commentary on Recommendation 6 suggests that the national review committee should have a lay majority. Referral for further assessment or investigation is a serious matter. It is our view that that the structure of the committee should reflect that of the committee adjudicating in fitness to practise cases. Further, we believe that medical regulation should be seen as a partnership and there should be equal lay and medical representation on this national committee.
- It is not clear (from Recommendation 5) if the lay representative or the complaints management staff would be part of the decision making process about 'recording concern' or if the decision would rest with the Affiliate.

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## Complaints

(Recommendations 7-9)

- We believe the proposed Affiliate could have an important role in dealing with complaints that raise concerns about the performance or conduct of a doctor. This might encompass resolution, education, and remediation.
- In meeting with complainants the Affiliate should not have the power to answer on a doctor's behalf unless that doctor had been invited to attend.

## Investigation and adjudication by the GMC

(Recommendations 11, 12, 15)

- We support the separation of investigation and prosecution from adjudication.
- There is growing if reluctant acceptance that despite the recent GMC reforms, which have resulted in independent fitness to practise panels with lay membership, public and professional confidence calls for an independent tribunal.
- We strongly agree that doctors and the GMC should have right of appeal to the High Court against decisions of the independent tribunal.
- On balance we favour a process of appointment over election to the proposed tribunal; but some do not share this view. An alternative, with the aim of satisfying claims for representation, would be to reserve a number of places for elected members.
- It would be important for tribunal membership to represent the specialist expertise appropriate to the individual case
- The question has arisen of the locus of interim orders – is it with the investigative or the adjudicative body?
- There is much opposition to the proposal that other organisations should have direct right of referral to the adjudication tribunal, rather than to the investigative arm of the GMC.
- We note that the report does not address the problem of malicious reporting to the GMC, a matter in which that body has some experience.

## Links with the National Clinical Assessment Service

(Recommendations 13, 14, 32)

- We agree that GMC (alongside employers and contracting organisations) should make full use of the National Clinical Advisory Service (NCAS) in its assessment of practitioners in fitness to practise cases.
- We agree that the processes of NCAS should be developed further, and that they be subject to audit.
- We are also of the view that GMC assessment procedures are robust and have been properly evaluated and should be retained as the model for performance assessment.
- Little has been said about plans to incorporate evidence from other organisations in GMC investigations or how the system can be applied consistently across the United Kingdom.
- We wish to record that Colleges have strengthened their relationships both with NCAS and the GMC, with agreements to allow access to examination assessment instruments for use in GMC tests of competence.
- We think it important to encourage improved sharing of expertise between organisations, rather than attempt to develop new systems from scratch.
- We welcome proposals that enable more effective handling of health and addiction problems. We feel there should also be a strategy in place for prevention and examination of why doctors become mentally ill or addicted in the first place.
- We are glad that these recommendations reinforce the case for providing adequate rehabilitation and/or retraining for doctors in difficulty.
- We wish to note that NCAS has no direct jurisdiction in Scotland.

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Specifying remedial packages

(Recommendation 15)

- If the complaints system for doctors is to adopt a less judgemental and more remedial approach to investigations and adjudication, there will be a need for investment in mentorship support, pastoral care and effective retraining and remedial packages. We strongly welcome this part of the recommendation.
- We share concerns about how the NHS and other employers will pay for these desirable developments.

## Recommendations to assure and improve the quality of medical practice

Setting standards

(Recommendations 16, 17)

- We support the proposal to develop clear sets of standards for both generic and specialist medical practice.
- We see the need to translate and incorporate such standards, and those set out in *Good medical practice,* with others that express concepts of modern medical professionalism, into forms that allow assessment of performance.
- We wish to record that the Medical Royal Colleges with the specialist societies and patient representatives are closely involved in the setting of generic standards, besides standards for specialist groups.
- We see it as essential that the GMC, the Royal Colleges, and PMETB collaborate to develop a common reference template for these new standards, to ensure their roles are in harmony.
- We recognise that this proposal also aims to end perceptions that a doctor's employer is concerned only with contractual matters, such as deployment of clinical sessions and productivity, standards of care being the concern of the General Medical Council.
- Accordingly, whilst recognising that the issue lay outwith the terms of the review, we also urge that doctors' contracts contain a commitment by the employer to work to the same standards, to make sustained good practice a shared goal.

Appraisal

(Recommendations 18, 28)

- Opinion remains strongly divided, particularly between doctors in primary care and those in secondary care, on the longstanding issue whether appraisal should be formative alone or should incorporate a judgements about performance.
- We are firmly of the view that the supportive, educative, developmental and reflective characteristics of appraisal must be preserved and that it must not become a purely summative exercise associated with re-licensing.
- Clearly there is a need to find agreement on the purposes, focus and conduct of appraisal.
- There is agreement that annual appraisal should be standardised, consistent and rigorous, and that the process should be audited.
- There should be sound training for those who undertake appraisal and those being appraised.
- We note the statement in Recommendation 18 that judgements against performance should be made against the generic medical standards, but it omits to mention specialty standards. There is a view that (where they are relevant) specialty standards should also be included, as re-certification will be based on them and necessary information will be drawn from the appraisal process. Moreover, it is important that doctors should be able to discuss both the generic and specialty elements of their practice at appraisal.
- We recognise that appraisal as presently designed cannot undertake the multiple tasks of detecting poor practice, quality assuring practice, ensuring compliance with contractual obligations, improving practice and facilitating continuing professional development. Revalidation should not be based solely on appraisal.

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- Again we recognise that these Recommendations also seek to end false perceptions that an employer is concerned only with contractual matters such as deployment of clinical sessions and productivity, whilst the GMC is concerned with standards of care.

GMC/PMETB and medical undergraduate education

(Recommendation 19)

- We support the principle of seamless regulation and planning of undergraduate and postgraduate education and believe there are benefits in having a single regulatory body that oversees all medical education.
- PMETB has yet to prove itself with postgraduate education and we are unsure of the capability of PMETB to take on this function in the foreseeable future.
- Given the clear links between education, training and regulatory standards it seems logical for an independent and reformed GMC, through its statutory Education Committee, to retain responsibility for medical undergraduate education. We see no insuperable difficulty in overcoming problems raised by the formal split of F1and F2.
- We believe that provided GMC and PMETB work to common standards, with close collaboration and coordination through existing structures, they can achieve the desired seamlessness.
- Other elements that are key to the early professional and cultural development of doctors are found in the university and medical school environments, where the richness of encounters with colleagues of many disciplines and backgrounds is an essential adjunct to more formal medical education and training. In our view this should be protected and its oversight kept apart from, though closely related to that of the later postgraduate stages of training, where a narrower influence comes to bear. The educational culture and relationships of GMC, whilst anticipating those of PMETB, are valuably distinct and should be maintained.
- We see any move to unify undergraduate and postgraduate education as a longer-term development. In that context we see merit in proposals (made independently of the consultation) that a single body might oversee three bodies working in close collaboration, as now, with responsibility for undergraduate, postgraduate medical education, and continuing professional development respectively.

Language proficiency; standardised national examination

(Recommendations 20, 21, 22)

- We strongly affirm the importance of verifying language proficiency and also written and spoken communication skills. All are fundamental to the good, safe practice of doctors (and other health professionals). Communication in general and English language proficiency in particular must be assessed and assured to a higher standard than at present
- We support the proposal to explore introduction of a standardised national examination and believe it would provide a sound means of demonstrating that the standards reached at the entry of postgraduate training are the same wherever the doctor has received previous education and training.
- We are not persuaded of the benefits of transferring PLAB to PMETB, a body with no particular expertise or resources to support the delivery of assessments.

Medical student registration

(Recommendation 23)

- We support the proposals for medical student registration. Engagement with the processes of medical regulation at an early stage will encourage a strong professional ethos and promote seamless transition from student to responsible doctor. It will also help instil the sense of professional accountability that will be expected of them throughout their careers in medicine.
- We believe most medical schools would welcome the central development of a harmonised set of procedures and that the GMC could deliver this.

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Registration with healthcare organisation; locum appointments

(Recommendations 24, 25)

- We agree that all doctors should be registered with a healthcare organisation and come under local clinical governance processes linked to the GMC.
- We wish to note that NHS Professionals, for example, might need funding as a residuary body.
- It has been put to us that Recommendation 25, as set out, may be impractical. We seek greater detail.
- Thought needs to be given on how to ensure that locum doctors have the same assessment of performance as those in substantive posts. Generally this will need to cover a rather longer time frame than that of most single posts.
- We wish to note the importance of high quality references and to suggest that consideration be given to further development of best practice when references are sought or provided in respect of doctors who move from one health service organisation to another.

Revalidation, re-licensure, re-certification

(Recommendations 26, 28, 29 and 18)

- The Academy wholly supports the principle that throughout their careers doctors should be able demonstrate by revalidation that they are up-to-date and fit to practise. (See our comments under Recommendation 23 also, in respect of medical students).
- We support the proposal to divide revalidation into the processes of re-licensing and of re-certification, to identify and verify generic and specialty skills respectively. (Again we draw attention to our comments made above, under Recommendations 10, 28).
- We are clear that a statement or assessment of health and of probity should be part of re-licensing, and presume this omission was simply an oversight.
- Although the standards for re-licensure are to be are to be generic, it will not be possible to apply them in a way that is divorced from the specialty context of the practitioner's work. If based on *Good Medical Practice* – as doubtless they will be – this will surely entail some element of assessment of the practitioner's ability to provide good clinical care. Inevitably there will be overlap with the specialty standards for re-certification (described in Recommendation 17). This will need clarification in due course.
- Continuing professional development (CPD) should be seen as a key part of any scheme of revalidation. There will be a need for close linkage between appraisal and CPD to ensure that it is appropriate to the doctor's work
- In our view the Colleges should be the bodies responsible for setting the framework of CPD schemes
- There will be a need for clarity on how the processes interrelate including the link to appraisal.
- The development of re-certification introduces a regulatory function to the work of the Royal Colleges. There will be a need to define a new formal relationship with the GMC
- The Colleges stand ready to meet the challenges that re-certification brings. Further work and clarification are needed around:
  - External independent scrutiny of re-certification;
  - The relationship of the Colleges and their decision making processes;
  - Funding of the re-certification process and its development and data collection;
  - The role of appraisal in the re-certification process, particularly in regard to the information presented and discussed at appraisal;
  - The relationship between the Colleges and local clinical governance in the re-certification process, specifically in relation to the sharing of information from appraisal;
  - The need for trainees to be re-certified.

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Retiring Doctors

(Recommendation 27)

- We support the proposal to establish a working group to examine this area in more depth

Practitioner's change of employer

(Recommendation 29)

- We agree that prompt transfer of information from one employer to the next is essential.

$360^0$ feedback

(Recommendation 30)

- We recognise that $360^0$ feedback is considered to be a useful tool in appraisal and assessment and can provide information on performance.
- We support the use of standardised, validated appraisal instruments of proven value. However, we are advised that at present there is insufficient evidence that $360^0$ feedback is a suitable or sufficient tool on which to base re-licensure.
- There is firm support for establishing standards for $360^0$ appraisal. A range of suitable feedback tools could be assessed against these standards, as the first step towards approval by the regulatory body. Doctors would then be in a position to select their preferred tool from this approved range.
- However, we think it unlikely that a single appraisal tool would be capable of capturing all the information required about doctors in the different specialties and domains of practice.

Specialist certification

(Recommendation 31)

- We support the approach outlined here.

Clinical audit

(Recommendation 33)

- We affirm the value of well supported, well designed, clinically relevant audit.
- We support a rekindling of local audit in the context of governance and its essential part in continuing quality improvement.
- We emphasise the crucial importance of data quality to meaningful audit.
- Some remain unconvinced that a centralised advisory group would generate successful audit. On the other hand there is support for a system of accreditation of national audit of demonstrable high quality (assured by standards of accreditation) in which individual doctors and whole organisations could participate.

Monitoring events in primary care

(Recommendations 34-36)

- We support these recommendations in principle. (We draw attention to the fuller response made by the Royal College of General Practitioners).

Financial incentives to promote safe practice

(Recommendation 37)

- We agree that an expert group should explore the issues.

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## Recommendations to address the need for better information for the public, employers and professional bodies

(Recommendations 38-41)

- We support the aims of these recommendations.
- We emphasise our concern to protect the confidentiality of non-public information.
- We recommend that there should be a clear audit trail for access to the secure tier of information, which should accessible to the registrant. The registrant should be able to know who is accessing the secure level of their record and for what reason.

## Recommendations to address the structure and governance of the General Medical Council

(Recommendations 42-44)

- On balance we favour a process of appointment over election to the General Medical Council, but some do not share this view. An alternative, again with the aim of satisfying claims for representation, would be to reserve a number of places for elected members. (See above also, under Recommendations 11, 12, 15).
- We support the recommendation that the General Medical Council should submit a detailed annual report and be accountable to Parliament.
- We believe it is vital to generate professional ownership of the policies and standards set by the General Medical Council. This will only be possible if the Council and Royal Colleges work together to ensure that both generic and specialty specific standards of good medical practice are defined and maintained.

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## Appendix

The collective response of the Academy to *Better doctors, safer patients* has also been informed by the views of the following bodies. These bodies also have made formal responses to the consultation.

- Royal College of Surgeons of Edinburgh*
- Royal College of Physicians of London*
- Royal College of Physicians & Surgeons of Glasgow
- Royal College of Physicians of Edinburgh *
- Royal College of Surgeons of England
- Royal College of Obstetricians and Gynaecologists
- Royal College of General Practitioners
- Royal College of Pathologists *
- Royal College of Psychiatrists *
- Royal College of Radiologists
- Faculty of Occupational Medicine
- Royal College of Anaesthetists
- Royal College of Ophthalmologists *
- Royal College of Paediatrics and Child Health *
- College of Emergency Medicine
- Patients and Lay Group, Academy of Medical Royal Colleges
- Academy Subcommittee for Continuing Professional Development
- Academy of Royal Colleges in Wales

* Includes response of the Trainees Committee of this College.

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