Agenda item: M6

Report title: Developing the UK medical register

Report by: Jo Nicholas, Policy Manager - Regulation Policy, Strategy and Communication, jo.nicholas@gmc-uk.org, 020 7189 5376

Action: To consider

Executive summary
This paper sets out the results of our consultation on the List of Registered Medical Practitioners (LRMP), along with our conclusions and next steps. Our full consultation report, including a detailed question by question analysis, is attached at Annex A.

We committed to undertake a review of the LRMP in our corporate strategy (2014 – 2017). A significant amount of preliminary work was undertaken prior to the decision to consult. In March 2015 independent research found that LRMP offers limited information compared with some other jurisdictions and that it has not kept pace with the recent expansion of the GMC’s functions. The research found significant appetite for the development of the LRMP.

On the 5 July 2016 we launched a formal public consultation on our proposals to develop the LRMP. We received 7,741 responses to the consultation – the largest response rate to any consultation the organisation has ever run. The majority of respondents did not support the options set out for developing the register.

Recommendations
Council is asked to:

a) Consider the report of the LRMP consultation Developing the UK medical register at Annex A.

b) Agree that in the light of the consultation feedback, to limit further development of the register at the present time to:

(i) Enhancing its functionality in relation to the information it already contains.

(ii) Exploring with the Academy of Medical Royal Colleges the desirability and feasibility of collecting and recording information about doctors’ scope of practice.
Introduction

1. In our Corporate Strategy (2014 – 2017) we committed to ‘Undertake a review of the List of Registered Medical Practitioners (the online medical register) to explore ways of making it more accessible and more useful for patients, employers, and doctors’. This commitment was part of our wider programme of work to be a modern and proportionate regulator, and sought to make the register more open, relevant and useful to our key interest groups in their work and interaction with doctors.

2. As part of our preliminary scoping work, we commissioned independent research. In March 2015 the research reported that the List of Registered Medical Practitioners (LRMP) offers limited information compared with some other jurisdictions and that it has not kept pace with the recent expansion of the GMC’s functions. The vast majority of stakeholders involved in the research agreed that more information should be available on the register, but there was a wide range of views and much less consensus about what that additional information would be. We made some limited additions to the LRMP at the start of 2016 (including identifying on the register which doctors are in approved training programmes).

3. Council considered draft proposals for developing a public consultation on how to further improve the online medical register in February 2016, and agreed to go out to consultation as proposed and report back at the end of 2016. We launched a formal public consultation on our proposals to develop the LRMP on 5 July 2016. We received 7,741 responses to the consultation, the largest response rate to any consultation the organisation has ever run.

4. The vast majority of responses were from doctors and medical students, with a small number representing organisations, members of the public and other individuals. However, we engaged directly with a number of stakeholders including employers and patient organisations via numerous Regional Liaison Service sessions, and presented our proposals directly to audiences including medical royal colleges, NHS Workforce Forum and the GMC’s Responsible Officer Reference Group. We also commissioned a survey of public opinion through the online polling agency Populus.

5. We have now completed the full analysis of all responses to the consultation. This paper sets out the main themes, conclusions and next steps. The full consultation report is at Annex A.

Key issues raised in the consultation feedback

The purpose of the register

6. There was a recurrent view that the extension of the register constituted ‘over-regulation’ and ‘grotesque…mission creep’ beyond our proper remit. The majority of
respondents said that the purpose of the register should simply be to provide assurance that those on the register are appropriately qualified and fit to practise medicine in the UK. They felt that the register serves this purpose well currently, and did not think there was a need for change. The Medical Defence Union commented 'The information the GMC publishes about registered doctors must be consistent with its primary purpose as a regulator of protecting patients and no more than is required to comply with that duty'.

7 One of the main concerns highlighted by respondents was that providing additional information on the register would create an advertising and marketing tool for doctors, allowing patients to ‘shop around’ leading to increased privatisation of healthcare. Respondents were concerned that the additional information would turn the register into an ‘online CV’ or a kind of ‘Facebook for doctors’.

Safety and privacy

8 The most common concern about the options put forward related to the risk to doctors’ safety and privacy if additional information is provided on the register. Many of these concerns were based on a misunderstanding that the GMC was proposing to publish personal data, such as home addresses. There was no proposal to require doctors to put their sensitive personal data into the public domain, nor would we contemplate doing so. Nevertheless, there was anxiety around potential harassment and stalking, as well as discrimination, fraud and identity theft, with particular roles or specialties more vulnerable. One doctor commented ‘Doctors have the same rights to privacy as any other member of the public. This must be balanced against the GMC’s remit to protect the public. Little of this additional information offers protection to the public but much of it severely effects the privacy of doctors’.

Additional information on the register

9 The consensus was that no additional information should be provided on the register, even if that information was to be provided on a voluntary basis. One consultant felt there is ‘simply no compelling safety argument’ for providing additional information on the register and most felt that adding the categories described to the register would not be of value to the public.

10 We asked respondents to select from a list of options the categories of information that they thought would be helpful to include on the register. The majority of respondents did not think that any of the categories of information were helpful to include on the register. The most popular category selected was credentials (14% support) followed by scope of practice (12% support). The least popular categories were a link to recognised feedback websites (2% support), registrant’s photo (3% support) and a link to the website of the place a doctor works (4% support).
11 A significant number of respondents raised the potential for some of the information to be used to discriminate or disadvantage certain groups of doctors, and advantage others. In particular, languages spoken and a photo could encourage discrimination on the basis of ethnicity, religion and age. For example, a doctor in training said ‘given recent events such as an increase in racist attacks and the recent decision to reduce the number of doctors by the current health secretary, by defining and classifying a doctor by what they look like, you could be opening up the doors to even more judgment by the colour of someone’s skin or where they are from - neither of which should matter at all’.

12 One GP said ‘…gaps for travel or maternity sickness could all appear as though [the] doctor had just taken time out or been unemployable’. Some worried that doctors would be tarnished from working in troubled hospitals, with one respondent saying ‘Junior doctors who have been sent to hospitals that have been rubbished in the press will be forever linked with that hospital’.

A tiered approach to the register

13 The tiered approach to the register reflected the limitations to our current legal framework. We suggested a voluntary approach to potential new information on the register.

14 One of the main concerns expressed by all respondents was that over time doctors will feel under pressure to add voluntary information to the register and that there will be an expectation to do so as standard practice, so as not to be ‘adversely judged by the public’. A doctor in training said ‘Some may feel that their doctor is ‘less trustworthy’ when they just chose to protect their private life.’ Another doctor said ‘Patients and the public may associate a ‘more full’ entry on the register with greater experience or clinical ability which may not necessarily be true’.

15 Many were concerned that the voluntary information could be misinterpreted by members of the public. One respondent said ‘The fact that doctor A can speak 7 languages or has 20 letters after their name bears no link to them being a better/more caring/ more trusting doctor than doctor B who speaks one language with their sole medical degree.’ A GP commented ‘excessive amounts of information may be complex and confusing and may make the register less accessible’.

Accuracy and validity

16 Most respondents felt that all information provided on the register should be verified in order to preserve the integrity of the register - if we cannot verify the accuracy of information provided, it shouldn’t be on the register at all. Respondents said that there is a public expectation that all information on the GMC register is accurate. There were concerns that voluntary information provided on the GMC register would
give false assurances to members of the public that the information is verified by the GMC. A member of the public said ‘no information should be included without direct verification, sampling is completely unsatisfactory and risks consequential errors in published information’.

Cost and burden

17 A significant number of respondents referred to what they saw as the cost implications of the proposals and the resources required to maintain and verify any additional information. They assumed a ‘likely increase in annual fees to maintain this Tier 2 [voluntary] information’. A doctor in training said ‘Increasing the data held on the register will increase costs at a time when the profession has already experienced many years of pay freeze.’ In fact none of the options presented would have impacted on the Annual Retention Fee (ARF).

18 Doctors also highlighted the burden of providing any additional information, and keeping that information up to date. This would be particularly challenging for those who moved roles, such as doctors in training.

Enhancing the functionality of the register

19 We asked how we can improve the register and make it more user friendly and we received many helpful suggestions. Many respondents recommended an improved search function including the ability to search by specialty and location as well as what the person is ‘known as’ and what the person’s name ‘sounds like’. We received recommendations to clarify and simplify the language used on the register, making sure that lay terms are used wherever possible, with abbreviations clearly explained. Respondents also recommended improvements to the layout and navigation of the site, such as reducing the number of clicks required to access relevant material, reducing the number of ‘pop-up windows’, and giving the register given a more prominent location on the GMC home page.

Conclusions and next steps

20 There was a difference between the feedback we received during the scoping and research phase of this project, and the responses we received through the consultation. We moved forward with this consultation on the basis of the support we received in the early phases of this project.

21 There was a clear lack of support at the time of the consultation for the options we had put forward to develop the online medical register. This was despite the independent research in 2015 having indicated a consensus for at least some changes, and feedback through other engagement demonstrating an appetite for improvement. Nearly all respondents objected to adding further information to the
register, and most respondents wanted to limit the purpose of the register to providing assurance to the public that a doctor is registered and licenced to practise medicine in the UK.

22 We have listened to the concerns of the respondents and, in the run up to Council, published a blog which has been well received. Their views, along with the large volume of responses received, demonstrate that we need to be very cautious in considering changes to the register at the present time.

23 We will, however, continue to develop our plans for credentialing following the positive outcome to our consultation in 2015.

24 We are also working with the Academy of Medical Royal Colleges to explore the desirability and practicalities of collecting and possibly recording information about doctors’ scope of practice. Once that work has been completed, we may wish to consult further on that issue, should we conclude that there is value in taking matters forward.

25 As part of phase one of our digital media strategy, we are intending to do work to improve the look and functionality of the LRMP. The helpful suggestions provided in response to the consultation will help to inform this work going forward.

26 We will reflect on any wider lessons for the future, recognising that there may have been particular external factors at the time of the consultation that could have influenced respondent’s views.

27 The consultation report in Annex A will be published alongside the Council papers on our website on 21 February 2017. To support its publication, we will contact some of the key stakeholders who responded to the consultation to update them on the outcome. We will also include an update on the outcome of the consultation in our e-bulletin for stakeholders and doctors in early March 2017. Should Council agree with the recommendations, we will issue a joint statement with the Academy of Medical Royal Colleges in relation to working together to explore the practicalities of collecting and maintaining information about doctors’ scope of clinical practice.
Developing the UK medical register: final consultation report

About the consultation

1. The List of Registered Medical Practitioners (LRMP – also called the ‘medical register’) is our unique national database of the doctors registered and licensed to practise medicine in the UK. Our consultation considered how we can improve the register so that it provides more and better information, and is easier to use.

2. Our ambition is to have the most advanced, transparent register in the world. To achieve this the register must:

   a. Continue to be a trusted source of reliable, validated information.
   b. Provide information that is relevant and useful to those who wish to consult it.
   c. Command the confidence of doctors about the information the register holds about them.
   d. Reflect changing public expectations about the information patients wish to know when accessing healthcare.
   e. Exploit technological advances for the provision of online information.
   f. Be accessible and meaningful to both expert and non-expert users.

Our consultation sought views on how we could achieve this.

Background

3. In March 2015, we commissioned independent research which explored how the LRMP is currently being used and how it can be developed to become more responsive to stakeholders’ needs in the future. The research found that LRMP offers limited information compared with some other jurisdictions and that it has not kept pace with the recent expansion of the GMC’s functions. The majority of stakeholders who took...
part in the research expressed a clear appetite for the register to offer more than it currently does, although there were mixed views on the type of information to include.

4 Following this research some limited changes to the register were introduced on 18 January 2016.

   a Whether doctors are in GMC-approved training programmes and the specialties in which they are training.

   b The name of each doctor’s Responsible Officer and the Designated Body which is responsible for the revalidation of their licence.

   c Which doctors are GMC-approved trainers of doctors undergoing GP training.

5 We received a very small number of complaints regarding the changes which have otherwise been very well received (and were implemented with minimal burden or cost).

6 Our preliminary research indicated that there is a public interest in developing and expanding the information presented on the LRMP and improving its functionality. Our view was that it should be more open, relevant and useful to our key interest groups.

Methodology

7 On the 5 July 2016 we launched a formal public consultation on options to develop the LRMP. The consultation was open for 12 weeks, closing on 7 October 2016, and asked respondents to consider:

   a How the register can better reflect a doctor’s past attainment and current capabilities.

   b How we make sure the register is flexible enough to adapt to changes in regulation, such as the introduction of new qualifications or forms of accreditation.

   c How to safeguard the integrity of the register while increasing the range of information it shows.

   d The balance between the openness of a public register and doctors’ privacy.

   e Ways to improve the experience of everyone who uses the register and to make it as accessible as possible.
The purpose of the consultation was to give people an opportunity to tell us what they thought about the options put forward. We asked 13 questions. For most questions, respondents were invited to tell us whether they agreed, disagreed or were not sure about an aspect of the proposal. Respondents were able to make free-text comments in relation to their response. One question asked respondents to select options they liked from a range of categories of information that might be included on the register. Respondents did not have to answer all of the questions if they wanted to focus on a particular aspect of the proposals.

People were invited to reply to the consultation through our consultation website, or by completing the text boxes on the consultation document and emailing or posting their response to us.

We reviewed all of the responses and identified themes and areas of consensus or differences. We broke down the analysis, where possible, by respondent groups. This helped us understand if there were any distinctions between the different categories of people and organisations. We have used terms such as ‘the majority’ and ‘many’ to refer to a strong theme or level of consensus. ‘Some’ and ‘a number of’ refer to a theme we identified, but not the main theme amongst the respondents. ‘Few’ or ‘a small amount’ refers to a theme a small number of respondents raised, and we thought it was important to capture these views in the overall analysis.

In reporting the quantitative responses for each question, we provided the number of respondents who said ‘yes’, ‘no’, ‘not sure’ and the number who did not provide any response. As well as providing the statistics for all respondents, we broke down each question into organisation, doctor, member of the public and all other individuals.

Alongside our formal consultation, we undertook a number of other initiatives to get feedback on the options discussed.

Omnibus survey

Populus interviewed 2,101 UK adults online between 21 and 22 of September 2016. They asked a range of questions designed to help us understand how people search for doctors online, what sources they look at, their existing knowledge of LRMP, and how helpful or unhelpful certain pieces of information on the register would be. Where relevant, findings from this survey have are included in the analysis of the consultation questions within this report. The responses to this survey demonstrated a higher level of support for additional information on the register than the responses to the consultation.

Feedback from sessions facilitated by our Regional Liaison Service

Throughout the consultation period, our Regional Liaison Service held a number of sessions, workshops and discussions with doctors, employers and patients and the public. The feedback we received from the sessions with doctors correlates strongly...
with the feedback we received through this consultation. Feedback from patients demonstrated more support for adding some additional information to the register. Their findings have been included in the analysis of the consultation questions within this report.

**Patients Association**

15 The Patients Association asked their contributors for their opinion on developing the LRMP using eight questions based on the questions we asked in our consultation. They received 127 responses, which were generally supportive of including more information on the register. We have included a summary of these responses where relevant throughout the report.

**About the respondents**

16 We received 7741 responses to the consultation, the largest response rate to any consultation we have ever run. We received 81 responses from organisations and 4961 responses from individuals. However, 2699 respondents did not identify whether they were individuals or organisations (blanks). Based on their free text responses, we believe that most of these respondents are individual doctors.

<table>
<thead>
<tr>
<th>About the respondents</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation</td>
<td>81</td>
</tr>
<tr>
<td>Individual</td>
<td>4961</td>
</tr>
<tr>
<td>Blanks</td>
<td>2699</td>
</tr>
<tr>
<td>Total</td>
<td>7741</td>
</tr>
</tbody>
</table>

**Organisations**

17 We received 81 responses from organisations. The table below sets out a breakdown of organisations by category. Organisations self-selected their category from a list. Where organisations selected more than one category, we used the primary category they identified. A number of organisations did not select a category.

<table>
<thead>
<tr>
<th>Organisation category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body representing doctors</td>
<td>20</td>
</tr>
<tr>
<td>Body representing patients</td>
<td>5</td>
</tr>
<tr>
<td>Government department</td>
<td>5</td>
</tr>
<tr>
<td>Independent healthcare provider</td>
<td>3</td>
</tr>
<tr>
<td>NHS/Social care organisations</td>
<td>13</td>
</tr>
<tr>
<td>Postgraduate medical institutions</td>
<td>6</td>
</tr>
<tr>
<td>Regulatory body</td>
<td>3</td>
</tr>
<tr>
<td>Blanks</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
</tr>
</tbody>
</table>
Individuals

18 4961 respondents identified themselves as individuals. Doctors and medical students made up the overwhelming majority of these respondents. A significant number of respondents who identified as an individual did not provide any further information about what category of individual they were.

19 We have broken down the doctor category further. Doctors in training made up over half the respondents who identified as doctors. There were a number of doctors who did not provide further information.

<table>
<thead>
<tr>
<th>Individual categories</th>
<th>Number</th>
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<tbody>
<tr>
<td>Doctor</td>
<td>4042</td>
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<tr>
<td>Medical educator</td>
<td>8</td>
</tr>
<tr>
<td>Medical student</td>
<td>92</td>
</tr>
<tr>
<td>Member of the public</td>
<td>80</td>
</tr>
<tr>
<td>Other healthcare professional</td>
<td>29</td>
</tr>
<tr>
<td>Blanks</td>
<td>710</td>
</tr>
<tr>
<td>Total</td>
<td>4961</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual doctors</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>835</td>
</tr>
<tr>
<td>General practitioner</td>
<td>622</td>
</tr>
<tr>
<td>Medical Director</td>
<td>13</td>
</tr>
<tr>
<td>Other hospital doctor</td>
<td>111</td>
</tr>
<tr>
<td>Other medical manager</td>
<td>13</td>
</tr>
<tr>
<td>Sessional or locum doctor</td>
<td>60</td>
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<tr>
<td>SAS doctors</td>
<td>105</td>
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<tr>
<td>Doctors in training</td>
<td>2198</td>
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<tr>
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<td>85</td>
</tr>
<tr>
<td>Total</td>
<td>4042</td>
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</tbody>
</table>
### Feedback about our proposals

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All respondents</strong></td>
<td>1979</td>
<td>3619</td>
<td>947</td>
<td>1196</td>
</tr>
<tr>
<td><strong>Organisations</strong></td>
<td>34</td>
<td>16</td>
<td>10</td>
<td>21</td>
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<tr>
<td><strong>Doctors</strong></td>
<td>1126</td>
<td>1895</td>
<td>580</td>
<td>441</td>
</tr>
<tr>
<td><strong>Members of the public</strong></td>
<td>42</td>
<td>13</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td><strong>All other individuals</strong></td>
<td>73</td>
<td>41</td>
<td>18</td>
<td>707</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Blank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All respondents</strong></td>
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<td>5866</td>
<td>365</td>
<td>1209</td>
</tr>
<tr>
<td><strong>Organisations</strong></td>
<td>15</td>
<td>39</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td><strong>Doctors</strong></td>
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<td>3249</td>
<td>206</td>
<td>448</td>
</tr>
<tr>
<td><strong>Members of the public</strong></td>
<td>24</td>
<td>28</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td><strong>All other individuals</strong></td>
<td>15</td>
<td>89</td>
<td>26</td>
<td>709</td>
</tr>
</tbody>
</table>

Responses to question 1 and question 2 were very similar. In many cases responses were simply copied over from question 1, or were a summarised version of the response to question 1. We have combined the analysis of questions 1 and 2 to avoid duplication.

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1 In this table, and the following tables, ‘blank’ refers to the number of respondents who did not select either ‘yes’, ‘no’ or ‘not sure’. However, they may have provided comments in relation to the question, which were taken into account in our analysis.

2 In this table, and the following tables, ‘All respondents’ refers to organisational responses, doctors, members of the public, other individuals, as well as those who did not tell us whether they were an organisation or an individual.

3 In this table, and the following tables, ‘All other individuals’ refers to those respondents who told us they were individuals, but are not doctors or members of the public. For example, it includes medical educators, medical students and other healthcare professionals. It does not include those respondents who did not tell us whether they were organisations or individuals.
The consultation document explained the historical use of the register to 'help patients and the public distinguish between qualified and unqualified doctors'. It then went on to discuss the changing context of medical practice and patient expectations and said that ‘If the medical register is to remain relevant and useful, it must evolve to meet the changing needs of those who use it’ and ‘we believe we need to make more information available to meet today’s expectations’.

In question 1, 26% of respondents said that they agreed with the purpose of the register as stated in the consultation document, which included the need to evolve to meet changing needs. Organisations and members of the public appeared to support our stated purpose of the register more than individual doctors. In question 2, only 4% of respondents said that they thought the register should serve an additional purpose.

2814 (36%) respondents provided additional comments to support their response to question 1, and 1416 (19%) respondents provided additional comments to support their response to question 2.

Recognising the need to improve

A small number of respondents recognised the need to adapt to changing needs and expectations and agreed that the register should better reflect modern practice and in particular include any conflicts of interests.

In particular, members of the public said it would be helpful to include on the register more information about what doctors are able to do within specialties, qualifications, training and experience, conflicts of interests, fitness to practice concerns and complaints and in particular whether a doctor works in both the NHS and private sector. One member of the public commented ‘The register needs to have info on specialisms, training and continued professional development, and list of employment if it is to be of any use to patients’.

Interestingly the Omnibus Survey of 2000 members of the public found that only a quarter of respondents had ever searched online for information about a doctor and only a third of respondents were aware of the GMC’s register. The most common reasons for searching online for information about a doctor was to check what area(s) of practice the doctor specialised in (24%) and searching for a new GP upon moving to a new area (22%).

Very few doctors recognised the need to develop the register to remain relevant for users. One consultant said ‘I agree and I also agree that the register in its current form has insufficient information to allow patients and organisations to form a reliable opinion as to a doctors credentials and capabilities’ A doctor in training expressed support for the register serving an additional purpose, commenting ‘Should provide
Disagreement to changing the register

27 Most respondents felt that the register should simply be a list of those doctors who are qualified to practise medicine in UK. They said that information currently provided on the register is sufficient for providing assurances to users that those on the register are licensed and fit to practise medicine. One doctor commented ‘This is a register. The purpose is not to sell credibility or determine who to trust with their care; that is the employing organisation’s responsibility… the question the register has to answer is: who is on the register and have they revalidated?’ Similarly, a doctor in training said ‘I believe that the official register serves the function of informing patients that I am registered to work as a doctor in the UK. That is appropriate and provides a useful service to the public’.

28 These views were also reflected by a number of members of the public who commented that there is an assumption that hospitals and employer organisations perform the necessary checks to ensure that a doctor is fit to practise. They said that if members of the public wish to find out more information about a medical professional they will find this information through hospital websites rather than accessing the LRMP.

29 Respondents said the purpose of the register should be consistent with the obligations and duties of the GMC as set out in the Medical Act. The GMC should simply act as the regulator of the medical profession, changing the purpose of the register risks extending the GMC’s role beyond its remit. The Medical Defence Union commented ‘The information the GMC publishes about registered doctors must be consistent with its primary purpose as a regulator of protecting patients and no more than is required to comply with that duty’.

30 The Medical Protection Society commented ‘The GMC’s ambition should be for information held on the register to be fully up-to-date, accurate, and dependable. This is the register’s core purpose and current function, and should remain so’.

31 Respondents also felt that additional information should be limited to that which is strictly necessary to achieve the aims of the GMC and the GMC should not attempt to duplicate information on the register which is provided elsewhere. Respondents also felt that processes such as revalidation, appraisals and assessments should be enough to provide assurance to the public that doctors are appropriately qualified, if these processes do not provide assurance, it is the processes that need developing, not the register.

32 Many respondents did not agree that there was a greater need or demand for further information about doctors, or were sceptical about this ‘need’. Many wanted to see
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33 Evidence of this and some provided anecdotal evidence that they have never been asked for further information by a patient beyond what is already available on the Register. A doctor in training said ‘Public expectations of what they should be able to find out about a doctor may not always be appropriate and should not be treated as the main driving force for information we are required to share’.

34 Respondents were clear that the register should not exist for the purpose of allowing users to make choices about care. One doctor in training commented ‘I find it troubling that the register is being transformed into a tool to help patients select their preferred medical practitioner, a purpose for which it was never designed’.

35 The Information Commissioner’s Office (ICO) said ‘The purpose for the collection and publication of any additional information would have to be carefully considered to ensure that this is also legitimate, proportionate and justifiable in terms of the Data Protection Act 1998’s first principle requirements of being fair, lawful and in accordance with an appropriate schedule condition’ and the GMC needed to have a ‘legitimate and clearly defined purpose’ for processing the data we proposed to collect within the consultation.

Risks involved in adding additional information to the register

36 Many respondents put forward risks or disadvantages to including more information on the register – including respondents who agreed that the register needs to improve. These are expanded upon in later questions to this consultation. In summary, the main risks highlighted were: damaging the value or robustness of the register; validating the accuracy of the information; confusing the public; individual privacy and safety; disadvantaging or the potential to discriminate against groups of doctors; the use of the register for advertising or marketing.

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Blank</th>
</tr>
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<tbody>
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37 3455 (45%) respondents said that they agreed that these are the right principles to guide the inclusion of additional information on the register. 1994 (26%) respondents provided additional comments to support their response to this question.

38 Although this question was about the principles that should guide the future development of the register, many of those who provided comments took the opportunity to go further and set out strongly held views about the sort of information that should, or should not, be included on the register. These views demonstrate a remarkable degree of consistency across all groups of respondents.

**Misunderstandings**

39 Many respondents misunderstood what was actually being proposed in the consultation paper. For example, the most common concern raised, both by those who supported, and those who disagreed, with the principles, related to the risk to doctors’ privacy and safety if additional information is provided on the register. This is a perfectly legitimate viewpoint, but it was repeatedly linked to the belief that doctors will be ‘forced’ to disclose to the GMC sensitive personal data such as their home address, email address, phone numbers and date of birth, and that the data would be published and sold to third parties. One consultant wrote ‘I am truly gobsmacked that someone...has come up with the idea of publishing personal information such as our home address”. Another commented that the ‘public should [not] have the right to access details such as home address, telephone numbers or email addresses’. Yet nowhere in the consultation is it stated or implied that such information would be requested or published. Furthermore, the consultation made it clear that any additional information included on the register would be provided on a voluntary basis. Nevertheless, even if these comments are based on misunderstanding, they illustrate the depth of feeling expressed by many of those who responded.

**Qualified support for the principles**

40 Although 3455 respondents said that they agreed with the principles, their answers were often qualified with detailed concerns. There were relatively few who felt able to say unequivocally that the principles ‘appear comprehensive enough to me’ (a consultant). Supportive comments were more likely to come from organisations than individuals. The Independent Doctors’ Forum wrote that ‘we should not be Luddite and should embrace new technology’. The Royal College of Surgeons of Edinburgh agreed that the ‘register needs updating’. The Royal College of Anaesthetists referred to ‘laudable principles to guide the development of the register’. The RCGP said that they were ‘appropriate guiding principles’ but nevertheless disputed the need for more information on the register. This was echoed by one doctor in training who supported the principles but did not think the proposed expansion of the register fitted the criteria. A consultant felt the principles were ‘fine with regards to the concept of data collection’ but noted that this was not a comment on whether the data should then be published. Another felt that the ‘principles are reasonable’ but the ‘NEED is negligible and intrusive’. A further concern was that ‘Whilst the principles in themselves appear
relatively sound, it is the translation...into practical steps which is important'. Professional Standards Authority supported the principles but wanted an additional test of 'clarity to the public and employers'. Importantly, the Information Commissioner’s Office supported the principles set out in the consultation document.

Doctors’ privacy and safety

41 The British Medical Association (BMA) wrote that the ‘individual principles have merit, but the principles as a whole need to be strengthened. It highlighted a concern about doctors’ ‘right to a private life’ and safety which was the dominant theme among all those who commented, regardless of whether they agreed or disagreed with the principles. Although most members of the public who responded were supportive of the principles, even here there was some anxiety about invasion of doctors’ privacy and a view that there was ‘too much emphasis on private life’. This was echoed by medical students who felt that personal information should not be publicly available and that the principles would ‘inadequately protect doctors’. One doctor in training expressed ‘grave concerns regarding my privacy and safety’ and another encapsulated the views of many in writing that ‘both patients AND doctors need to be protected’ and that the principles ‘prioritise the needs of the public above the protection and privacy of doctors’. Fear of stalking, harassment, identity fraud and violence perpetrated against doctors and their families was a recurrent theme. Even those who felt it was reasonable to publish ‘professional information’ were worried about their personal information. A doctor in training was one of several who saw this as a means that ‘the GMC will use...to justify whatever new data they want’.

42 The principles had specified that information published online ‘must not jeopardise the reasonable expectations of doctors about their privacy’. A significant minority of respondents interpreted this as meaning that the GMC would decide what was ‘reasonable’ and objected that this was therefore a qualified principle which would not protect their privacy or safety. In fact, by making the inclusion of additional information in the register voluntary we have placed the decision about what is reasonable entirely in the hands of individual doctors. But, irrespective of whether doctors’ fears are well founded, we cannot overstate the depth of feeling expressed by respondents.

Over-regulation and commercialisation

43 There was also a recurrent view that the extension of the register constituted ‘over-regulation’ (consultant) and ‘grotesque...mission creep’ beyond our proper remit. One medical student felt that the proposals failed to distinguish between a ‘register and directory’ while a doctor in training thought additional information would amount to ‘advertising on the register’, turning it into an ‘Argos catalogue’ and another caricatured it as ‘Facebook for doctors’. Such views linked to a sense that the proposals represented the ‘deprofessionalisation’ of doctors and the commercialisation of the register. A GP typified the views of several respondents in saying that the GMC should
not ‘become some sort of consumer feedback website’ and a consultant insisted that additional information could ‘more usefully be located on the NHS Choices website’.

No need for more information on the register

At the heart of the sense of mission creep was a view among doctors that there is ‘not... a problem’ with the existing register that ‘needs a solution’. ‘You have got [sic] identified a clear rationale for publishing data’; the ‘public are not looking for this information’; ‘the current level of information is more than enough for public information’ are typical comments, even from those, such as the Royal College of General Practitioners (RCGP), who supported the principles. Added to that, some were of the view that ‘patients cannot process uninterpreted facts meaningfully’ (consultant). A GP summed up the views of many doctor respondents: ‘The GMC should only hold whether a doctor is licensed to practise or not...I strongly oppose all such expansion of the register’. Many simply felt that placing any additional information on the register was not compatible with the purpose of the register: ‘The purpose of the register is to be a register’. A rare voice of support came from a consultant who felt ‘these are all important pieces of information’ and cited the example given in the consultation document about the information on the register concerning Dr Hulf.

Scope of practice

Several questioned why it was appropriate for a register to record even their scope of practice. A consultant saw it as ‘a mechanism to limit and control the working lives of doctors for not good purpose’ and a student described the proposal as ‘unreasonable’. A doctor in training said that recording scope of practice ‘is not an essential part of a register’. One doctor in training thought such information would be better placed on an employer website than on a register. A consultant similarly asked ‘Is that not accessible elsewhere?’ Several respondents questioned whether it was possible to ‘define meaningful account of a doctor’s actual scope of practice to a lay person’. This was echoed by another doctor in training who felt that scope of practice information would be ‘liable to misinterpretation by members of the public’. Taking a different view, a GP said that the register should ‘feature your current line of work’ and noted that it is ‘not acceptable’ that for some doctors the specialist register gives a misleading account of what they do.

Practicality

A consultant felt that the principle of recording scope of practice was ‘reasonable’ but questioned whether it was ‘achievable’. Others also questioned the practicality of the proposals. A consultant argued that ‘scope of practice can vary from year to year’ and was concerned that doctors could be subject to regulatory sanctions if they failed to keep their entry up to date. Another said that although the principles were ‘sound’, ‘the register can only practically and safely hold very basic data, as the GMC will be unable to verify the veracity of extended data without very costly and unnecessary
extra administrative burden’. The Scottish Government (which did not support the principles) also questioned whether it would be ‘achievable without significant cost to the doctor’. A GP was one of several respondents who, while accepting the principle, pointed to the difficulty of verifying additional information such as scope of practice. Linked to this view, another GP said it was not enough that information on the register should be ‘capable of verification and validation’ it must be ‘actually verified and validated’ in order to maintain the integrity of the register.

Cost

47 The cost of expanding the range of information on the register was a concern for many. RAF Medical Services asked: ‘who would pay for this discretionary extension of the GMC’s role?’ A doctor in training complained the proposals would ‘not be practical and cost effective’. Another doctor in training regarded the proposed expansion of the register as coming ‘at the cost of doctors’ registration fees’, a view echoed by others who felt that the ‘cost would fall on doctors’. A respondent who regarded the principles as ‘reasonable’ nevertheless worried that in practice the costs would spiral ‘out of control’.

Question 4: Are there other principles that should be included? If so, what are they?

48 1622 (22%) respondents provided comments in response to question 4. These comments were broadly consistent with comments provided in response to question 3, and were consistent across different groups of respondents.

49 Of those who said ‘no’ but provided no further detail, it was not clear whether they could not identify any additional principles, or they disagreed with the overall proposal to include additional information on the register.

Doctor’s privacy and safety

50 A significant proportion of comments focussed on concerns about doctors’ privacy and safety, including harassment, stalking, fraud and identity theft. The consultation document proposed the principle ‘must not jeopardise the reasonable expectations of doctors about their privacy and safety’. Respondents reinforced this principle, and many expanded on it or wanted it strengthened. Many doctors also wanted to amend another principle to ‘promote and protect the health and wellbeing of doctors as well as the public’. The Medical Protection Society (MPS) wrote that ‘The GMC should also state clearly, that the need to ensure the safety and privacy of a doctor and their family is an important principle for it to take forward. MPS is firmly of the view that the GMC owes its registrants a duty of care, and this should be reflected in the principles underpinning the information it seeks to hold on the register’.
51 Data protection was mentioned a number of times as a potential principle and one medical student wrote ‘In modern times it is becoming increasingly important to protect one’s data and making it all accessible in one place is worrying’. One doctor in training said there ‘should be a principle about how the data will be kept safe and how privacy will be protected’.

Consent

52 The need for the provision of additional information to be voluntary generated numerous comments. Overall most comments consistently agreed that the doctor had to consent to the publication of additional information or have ‘opt out clauses’ (doctor in training) and ‘doctors should be able to decide what other info is published’ (doctor in training). A very small number said that provision of the additional information ‘must be compulsory’ (doctor in training).

53 There were a small number of suggestions for ‘transparency’ to be a principle. One consultant wrote ‘Transparency – showing the source of information and perhaps allowing the doctor to add comments / notes – like they might for example on a credit reference file’.

Accuracy of information on the register

54 Some respondents highlighted the importance of making sure the information on the register was up to date and accurate and suggested this as a potential principle. The Medical Defence Union wrote ‘The list doesn’t say that the information must be accurate and up to date and, even if they are there by implication, we believe they are important principles that should be included specifically’. Similarly one doctor in training wrote that the register ‘must be quickly updated when details change, as is expected with a modern database’.

55 There were a small number of comments related to how the information would be kept up to date and whose responsibility this would be. The British Medical Journal (BMJ) wrote ‘we would like to see a principle about it being the responsibility of the medical practitioner to maintain the accuracy of the information on the register and to provide an annual return’.

56 A small number questioned whether there would be a right to challenge the information put on the register.

Any additional information must be ‘relevant’ and ‘necessary’

57 Some comments emphasised only providing information that was ‘relevant’ and ‘necessary’. A number of respondents made comments relating to proportionality and balancing a number of factors, such as how essential it was to the GMC’s functions to provide the information, how useful it would be to patients and the impact on doctors. If any additional information was to be published it must relate to a doctor’s
professional (as opposed to private) life. But overall, there was a strong sense that the information ‘held should be the minimal [sic] necessary’. The ‘current information is the maximum that should be in the public domain’.

58 Doctors in training in particular made the following comments ‘open and transparent to aims’; ‘must be limited to information that can provide useful information to patients and not contain irrelevant information collected and published for no reason;’ ‘must not be more than is required to perform the GMC’s statutory function’. One GP made the point that the register must accessible and meaningful to expert and non-expert users and that ‘excessive amounts of information may be complex and confusing’.

Advertising

59 There were a number of comments about the additional information being used for advertising. Some of these comments raised concerns about the potential for others to use the information to contact and advertise their services to doctors. Others felt that there were already numerous ways in which doctors could advertise their services to the public. One doctor in training wrote that it ‘…will expose us to further marketing and headhunting. If doctors want to pursue private interests, they should list their achievements on LinkedIn’. A consultant wrote ‘Any data that could contribute to commercialism or advertisement, whether by individuals or organisations, should be excluded’.

60 More generally, there were concerns that information would be used to judge, compare or denigrate individual doctors ‘Must not enable competitive/comparative value judgements about a doctor’s practice’. Although one GP was keen that the register be used to ‘promote positives of a career’.

Cost

61 Cost was a consistent theme throughout responses from organisations, medical students, doctors in training and doctors. Respondents were keen to avoid additional information on the register adding any burden on doctors or being paid for by doctors.

62 Doctors very much agreed that any additional costs should not fall to them or cause an increase in the annual retention fee. One doctor in training wrote ‘any further additions should be paid for by the government and not those on the register’ and a GP wrote ‘I would really resent paying additional time or funds to such a register’. Nor did they want increased information on the register to ‘financially benefit the GMC or any third party organisation’.

Suggestions for additional information to go on the register

63 Many respondents took the opportunity to state that they do not think that new information should be added to the register, and some provided further explanation for this view. The main reasons provided were that the additional information was of no
value to the public, the information was already available elsewhere and the provision of the additional information on the register went beyond the functions and role of the GMC. Some respondents also took the opportunity to provide their views on what should, or should not, be recorded on the register rather than suggesting additional principles. The main areas suggested were conflicts of interest, indemnity, accreditation and credentialing and scope of practice or area of specialty. These comments have been picked up across other questions in more detail.

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

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64 We asked respondents for their views on creating two separate tiers of information on the register. Tier one would contain the regulatory information that we require by law, including all the information that currently appears on the register. Tier 2 would contain only information that a doctor has voluntarily offered for inclusion on the register.

65 Over half of the respondents (53%) disagreed with the proposals for a tiered approach. Organisations and patients were more likely to agree with the tiered approach.

66 3940 respondents provided additional comments to support their answer. Many of the responses were about potential information on the proposed second tier, as opposed to whether they agreed with a tiered approach to the register. Similarly, it was sometimes difficult to understand if someone disagreed with a tiered approach, or the overall proposal of adding additional information to the register.

67 The findings from the engagement undertaken by our Regional Liaison Service strongly reflect the themes and concerns raised by respondents to this consultation.

Qualified agreement with the approach

68 A small number who agreed with the approach provided further comments to explain their agreement. For example, one doctor in training wrote 'I do not believe the GMC
register is the place for this information, but if the GM[C] (sic) is determined to press ahead, this sort of system would be preferable’.

69 Some who agreed overall identified difficulties or problems with the approach. For example, one GP wrote ‘Would be very difficult for locums who do not have a fixed work address’. A member of the public wrote ‘Very helpful for patients seeking further accurate and reliable information about a registered doctor, but appreciate there may be problems in gaining this information and also in keeping it up to date’.

70 A large number of those who agreed only agreed on the condition ‘that tier two information remains totally voluntary and there is no future change making it compulsory’ (medical student).

71 Respondents to the Patients Association survey were overwhelmingly in favour of a two-tier approach to the register. However, they were concerned that doctors might hide information or that information might not be truthful, and that the two-tier system might lead to confusion.

Voluntary nature of the information

72 Many disagreed because they thought that the voluntary information in tier two would become mandatory in time. This was consistent across all groups of respondents, including organisations and the public, as well as some of the respondents who agreed with the tiered approach. One doctor in training wrote ‘It is clear that the ultimate aim for the GMC is to progress to the tier 2 information being mandatory’. The MPS was ‘concerned that Tier 2 information could quickly become compulsory information rather than voluntary, thus making the tiered approach redundant’.

73 Some respondents said that doctors, particularly trainees, will be ‘compelled to enter the voluntary information’. There will be an expectation that if others are providing the information, they will also have to provide it. One medical student wrote ‘Having a register whereby some doctors include additional information will only put pressure on those not wanting to disclose such personal information into adding it. The fear would be that they would be seen to be less trustworthy when compared to somebody who chooses to’.

Missing information might create suspicion

74 Some expressed the view that those who did not provide the voluntary information might be viewed with suspicion, and people might think they have something to hide. A consultant wrote ‘There will inevitably be a suspicion that doctors who do not provide Tier 2 information have something to hide’. A member of the public confirmed this by writing ‘The absence of this ‘optional’ information from one profile compared to a complete profile would also serve to introduce public distrust in a doctor with little information from Tier 2 published’.
One medical student who answered that they were ‘not sure’ about the two-tiered approach wrote ‘Theoretically these pieces of extra information would be welcome but they wouldn’t truly be voluntary because if members of the public knew that some practitioners were not providing tier 2 information they would make judgements on that basis’.

The information is available elsewhere

Numerous respondents said that there was no point in having a two-tier system to collect this information because the information was easily available elsewhere. Examples included through employers’ websites, private websites and other databases. One GP wrote ‘Such information is readily available from multiple other sources currently (LinkedIn, the various commercial registers of medical practitioners, NHSE GP Performers List, Trust, GP Practice and CCG staff pages, Social Media etc)’. Similarly, another GP wrote ‘The information is available on a practice website, and this would be the first place a patient would look for it’.

Some respondents highlighted that they publish this information about themselves already and so it is already available to people who want it. One consultant wrote ‘If patients want further information they can look at my website’.

Advertising, commercialism and the role of the register

A large number of respondents disagreed because they felt the information in tier two was of a commercial nature and could be used for advertising. One consultant wrote that it would turn the register into ‘a professional advertising site’. A GP wrote the ‘GMC register should not be used as an ‘advert’ for individual doctors’. A member of the public wrote ‘I have concerns that doctors wishing to promote themselves, particularly those in private practice would submit additional information to attract potential patients and this goes against principles of fairness.

Many linked this to private practice and a move towards greater commercialism. For example, one GP wrote ‘I fear this approach would lead to the register becoming something of an advert for those doctors undertaking significant amounts of private practice’. A member of the public wrote ‘a tiered system would feed a private sector mentality of ’shopping around‘ for a doctor. This is wrong as the nhs is a national organisation and should remain so’.

These comments were closely linked to comments on the role of the register or the role of the GMC. Most of these comments stated that the GMC should only publish the information necessary for keeping a register, or only what is required by legislation. One GP wrote ‘You are confusing the two very different roles of producing a register of doctors qualified to practice and providing a directory of the services provided by them. The latter is not the role of the GMC’.

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Some doctors pointed out that, if using the NHS, patients couldn’t really choose their doctors anyway. One medical student wrote ‘The health system in the UK is not the same as other countries such as Canada and the USA, patients do not choose their doctor in the same way and this would not work in a system such as the NHS’.

A number of respondents expressed concern that the proposals would involve collecting and publishing data over and above that which the GMC has legal powers to collect, and that doing so would be an overreach of our duty to maintain the register. A consultant explained that ‘it is outside the remit of the GMC to compile and publish this data’, whilst a GP wrote ‘It is sufficient that you fulfill your legal duty. It is not necessary or appropriate for a regulatory body to take on the role of a marketing body’.

Cost and burden

Some respondents said that the responsibilities on doctors to keep the information up to date would be an added burden, and any cost of these changes to the register were not appreciated by any of the groups of respondents. A consultant wrote ‘I am not prepared to pay for this information which is available on many other sites in the world wide web’. A GP also wrote ‘Regulation of this may be quite costly and I’m not sure this is [t]he best use of the GMC doctor-funded resources’.

Lack of verification

Many respondents said that the lack of verification of this voluntary information would mean that the information might not be accurate. This could be because the information became out of date over time as doctors might not update their details. One doctor in training wrote ‘It adds opportunity for misuse and could undermine the trustworthiness of tier 1 information, and the register as a whole, as a result’. The Professional Standards Authority (PSA) wrote that it ‘could lead to a loss of reliability’ and ‘have an impact on public confidence in the reliability of any information on the register’.

A number of respondents highlighted the GMC’s responsibilities under data protection legislation to keep information on its register up to date. The Information Commissioner’s Office wrote that ‘it should be noted that under the DPA, as data controller, the GMC will have to take reasonable steps to ensure the accuracy of the data’.

Some commented on the limited verification. These views have been included under question 13 of this consultation.

Privacy and safety

A number of respondents took the opportunity say that additional information on the register such as photos and addresses was an invasion of privacy and could lead to issues around safety for individual doctors. One consultant who agreed with the two-
tiered approach wrote 'As an example I would not be able to provide practice details, since I am occasionally subject to threats of serious harm or death in my area of practice!' Similarly one GP wrote 'I do not want my photo and specific work place freely available online, as a woman it makes me feel vulnerable'.

Links to external feedback sites

88 A small number of respondents also took the opportunity to disagree with any linking of the register to external feedback sites. One consultant wrote it would be 'trial by social media'. A GP wrote 'The very presence of links to feedback sites will legitimise these sites, despite a dearth of evidence that such feedback on such sites are related to quality of practice or doctor'.

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

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89 Overall, 1193 (15%) respondents said that making the provision of some information voluntary would help to mitigate some of the disadvantages of the proposed two-tier model. 2245 (29%) respondents provided additional comments to support their response.

Qualified agreement

90 A small number of respondents agreed that making provision of some categories of registration information voluntary would help mitigate some of the possible disadvantages of our proposed two-tier model. However, their agreement was qualified.

91 For example, a number suggested that we would need to make patients aware that the voluntary information was not verified, and a disclaimer should be included on the register. Others said it was necessary to be clear that a lack of information did not imply a doctor has something to hide, and that some doctors are unable to provide additional information due to the sensitivity of their work. One respondent suggested
that to better mitigate against the disadvantages identified, tier 2 information could form a document completely separate from the register. This would make it clear to members of the public that doctors are not ‘withholding information from the register’.

92 Some members of the public said that disclosing additional information about a doctor’s practice should be mandatory. They did not see any risks in introducing a two-tiered approach to the register, particularly where additional information is already published elsewhere. One noted that currently people search the internet for information which may be misleading. Yet if doctors provided additional information on the register, there would be less incentive for people to look elsewhere to ‘fill in the gaps’. Some members of the public felt that the GMC should require more information from doctors, but it should be a doctor’s decision as to whether or not they want that information published.

Disagreement with a two-tier approach to the register

93 The vast majority of respondents took the opportunity to explain again why they did not agree with a two-tier approach to the register. These reasons mirror the comments provided in response to question 5: inaccurate and inconsistent information on the register; expectations on doctors to provide this information and disadvantage to those who do not; potential to mislead patients; there are other more appropriate forums to publish this information; impact on privacy and safety and a potential for the additional information to cause discrimination.

94 A small number of respondents said that the two-tier approach was simply a means for any negative consequences to be blamed on the doctor for providing the information in the first place, rather than GMC.

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

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2674 (35%) respondents agreed that there were groups of doctors who would be helped or disadvantaged by our approach to providing more information on the register. Doctors and organisations agreed more strongly than members of the public. 2595 (34%) respondents provided additional comments to support their response.

Those who will benefit from the approach

Respondents identified that those working in private practice would benefit from being able to provide more information on the register. One GP said 'The private sector docs who are trying to sell themselves will love this'. Similarly, many felt that commercial or private companies would also benefit from the availability of the information as the register would become a ‘marketing’ or ‘advertising tool’. One doctor in training said 'I think private companies will be helped by having this 'linked in' style profile of each doctor to help them with recruitment. The same goes for international recruitment agencies'.

Other people whom the approach might benefit included: patients (discussed below); Responsible Officers and Medical Directors for recruitment purposes; those doctors who are tech savvy; doctors overseas wishing to account for their absence; recruitment agencies. The Patients Association survey also said there might be benefits for those for whom English is not their first language, and those with mental health problems.

Benefits and disadvantages to patients

There were mixed views about whether the approach would benefit patients. Some respondents, particularly members of the public, identified that patients will be helped by the additional information by better facilitating patient choice.

However, respondents also cautioned that the additional information may confuse patients or lead them to making incorrect judgements. One doctor in training said 'patients will be given information that can be freely misinterpreted and add nothing to their care'. Some highlighted the complex nature of healthcare and one consultant said 'Information judged by general public without a true comprehension of healthcare system and facilities offered where an individual doctor works'.

The Patients Association acknowledged the benefits of more information being made available to the public but warned that adequate explanations should also be included. 'We welcome the GMC’s commitment to recognising changing needs of patients and believe that public has a right to be informed about their healthcare. New information must be adequately explained and how it can be effectively used'.

Groups that might be disadvantaged

Many respondents raised concerns that the safety of groups of doctors working in certain fields would be at risk. For example, one GP said 'Docs working in child
protection, family planning, abortion, prisons, reproductive health and forensic psychiatry may be endangered by this'. Some raised the concern that the freely available information would encourage stalkers and increase the risk posed to their victims. A similar concern was expressed for the victims of abusive relationships. This would disproportionally disadvantage women. One GP said ‘Any doctor who has had a stalker or similar would be hesitant to make information about their place of work known to the general public’.

102 A large number of respondents expressed concerns that the additional information on the register would give opportunity for certain groups to be discriminated against and thus inadvertently have a negative impact on patient care. One doctor in training said ‘This could lead to all sorts of discrimination e.g. employment depending on appearance, gender, what your hobbies are, where you went to medical school etc. Patients may decide not to see an appropriate specialist based on their interpretation of trivial personal information, delaying or preventing their own care’. Respondents referred to the ‘current anti-immigration context’ in the ‘post-Brexit Britain’.

103 Respondents identified that those who did not provide additional information on the register could be viewed with suspicion or perceived to have less experience or skills than colleagues with a full profile. One consultant said ‘It may look if you provide less information you are less qualified when you are only trying to protect yourself’.

104 The Royal College of Radiologists raised concerns about how the public may interpret information relating to qualifications. ‘Doctors who do not have, for example, additional, non-mandatory qualifications might be perceived as being of lesser value. Public perception may be that quantity equals quality and the very variable nature of consultant employment (which can only increase) may lead to confusion about value’.

105 A small number of respondents, including the Patients Association, highlighted that groups who are not ‘technologically savvy’ may be disadvantaged, as well as those with learning difficulties or English not being their first language. ‘Based on the Office of National Statistics data those without internet for households with one adult aged 65 or over, only 49% had internet access. In 2015, of the 14% of households in Great Britain with no internet access, 31% reported that this was due to a lack of skills’.

106 A small number of respondents suggested that having more information available on the register would increase the risk of doctors being victims of identity theft and fraud.
Question 8: Are there other disadvantages associated with the two tier model which we have not considered here? If so, how might they be mitigated?

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107 2341 (30%) respondents agreed that there were other disadvantages associated with the two tier model that we had not considered in the consultation document. 481 (6%) respondents said there were no additional disadvantages.

108 2075 (28%) respondents provided additional comments to support their response. Overall, respondents said that the disadvantages of a two tiered model significantly outweighed the benefits. The additional information was not seen as necessary, particularly given that much of it is already available to the public through another source. Respondents indicated that their preference would be not to include the proposed information on the register, or not to amend the function of LRMP.

109 A number of the disadvantages raised by respondents are not specifically related to the two-tier model, but relate to including additional information on the register more generally.

**Voluntary nature of the information**

110 The voluntary nature of the information in tier two was considered a disadvantage by many (although the vast majority of respondents did not think that it should be mandatory to provide the information). Many respondents said that those who chose not to provide tier two information would be perceived as having something to hide or being less skilled or experienced than their colleagues. One consultant said “There will be a perception amongst searchers of the register that doctors who do not provide complete Tier 2 information have something to hide or lack specialist skills/abilities.” A doctor in training said ‘Some may feel that their doctor is 'less trust worthy' when they just chose to protect their private life’. Another doctor said ‘Patients and the public may associate a 'more full' entry on the register with greater experience or clinical ability which may not necessarily be true’.

111 Respondents said that this would put pressure on doctors to share information that they did not want to share. There was a risk that ‘people may feel compelled by their
employer or colleagues to include information they may not feel comfortable having in the public domain’ (GP). Furthermore employers or others could put pressure on doctors to share tier two information. There was a worry that tier two information would, in effect, become mandatory. One doctor in training said ‘Trainees may come under pressure from Annual Review of Competency Progression (ARCP) panels and examination boards to publicise information about their success or process in training, no legislation exists to protect juniors who are vulnerable to exploitation through ARCP panels’.

**Discrimination and inequality**

112 Some comments specifically highlighted the possibility of information leading to discrimination, particularly the publication of photographs or information about languages spoken – ‘Language or place of qualification being used a proxy for race’ (consultant).

113 One consultant said that ‘By including photographs of doctors their families could also become targets of discrimination’. And a sessional or locum doctor said that 'Doctors are at risk of being prejudiced against for either race, education, ethnicity etc’. Some also highlighted a ‘Public prejudice against those with less experience in the uk or trained abroad, or in failing hospitals/practices’.

114 Some mentioned that the ‘very concept introduces inequality’. One doctor in training said ‘In the current system with minimal published information, everybody is on even-footing...introducing additional elements of choice and more fields of enquiry will self-evidently uproot this more even playing field. Some worried about the creation of a hierarchy amongst doctors. A GP commented, ’it must be clear that [a] 2 tier register doesn’t mean 2 tier doctors’.

115 Some respondents thought that a two tier model would advantage those in private practise as it gives them an advertising platform. One doctor in training commented ‘Those doctors heavily involved in private medical work are likely to invest considerable time and money in making their websites and feedback sites (which the register will link to) look as professional and polished as possible regardless of their actual reputation or skills’.

**Cost and burden**

116 A significant number of respondents referred to the cost implications of these amendments to the LRMP and the resources required to implement and maintain the additional information. They felt a disadvantage of the tier two model was a ‘likely increase in annual fees to maintain this Tier 2 information’ (consultant). A doctor in training said ‘Increasing the data held on the register will increase costs at a time when the profession has already experienced many years of pay freeze’. Some respondents suggested that those who want the information should pay for it, or that only those who upload tier two information should pay for it.
Accuracy and verification of information

Another commonly perceived disadvantage of the two tier model was felt to be the difficulties with ensuring the accuracy of the information in tier two. There were concerns about the administrative burden that keeping this information up to date would place on doctors, particularly given how quickly this information could go out of date, and the consequences that doctors might face if the information is not kept accurate. A considerable number of respondents felt that the GMC would have to take responsibility for keeping this information up to date.

Some also questioned whether there might “be a tendency for some doctors to exaggerate certain areas of skill / competency” (consultant).

Respondents also highlighted that the subjectivity of the data could be a disadvantage if there were not clear explanations and controls in place. They raised a potential to mislead rather than aid the public if it is not fully understood. For example, what some define as language proficiency may be a basic qualification, and for others might indicate that the individual is bilingual. Information “would need to be offered to the public with great caution in order not to mislead but to make best use of the valuable resource which is NHS staff diversity” (doctor in training). Another doctor in training said “People will get confused when they see differing amounts of information about different doctors”.

In relation to linking to feedback sites, the risk to doctor’s reputations was a disadvantage highlighted by many respondents. Responses highlighted that this is one sided data, with no right of reply for doctors if there is no way to take this information down or dispute the comments. Concerns were also expressed by many respondents that linking to these sites from the LRMP, indicates GMC endorsement of the information, and encourages subjectivity.

Suggestions for mitigations

Suggestions for mitigations mainly focussed on not putting additional information on the register, particularly tier-two information. Suggestions to mitigate these risks included the availability of options to quickly and easily take down, or hide, information; to include significantly less personal information; keeping private practice information separate from other information; clear explanatory information about the voluntary nature of tier two.

Disadvantages based on the types of information that could be published on tier two

Many respondents raised a risk to the safety and privacy of themselves and their families, as well as the risk of identity theft, fraud, junk mail providers and cold-callers. These comments have been taken into account as part of other questions in the consultation.
Purpose of LRMP and the GMC

A number of respondents said that the two tier model was unnecessary because the information is already available in other formats, it turns the register into an advertising platform and the provision of the information was outside the remit of the GMC. These comments have been taken into account as part of other questions in the consultation.

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

Respondents were asked to select from a list of options the categories of information that they thought would be helpful to include on the register. They were then asked to indicate whether the information should be Tier 1 or Tier 2 information.

The majority of respondents did not think that any of the categories of information were helpful to include on the register. The most popular category selected was credentials (14% support) followed by scope of practice (12% support). The least popular categories were a link to recognised feedback websites (2% support), registrant’s photo (3% support) and a link to the website of the place a doctor works (4% support). Responses from patients and the public reflected the overall responses.

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**Conflicts of interest/competing professional interests**

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**Credentials**

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Links to data held and verified by other recognised bodies, such as medical royal colleges

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Registrant’s photo

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A link to the website of the place a doctor works

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A link to recognised feedback websites

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However, both the Patients Association survey and the independent Omnibus survey demonstrated a much higher level of support for the inclusion of additional information on the register.

The survey conducted by the Patients Association asked respondents whether they thought the register should contain additional information. The majority of respondents said that it should, and the most popular categories selected were employment history and scope of practice.

The majority of respondents to the Omnibus survey said they would find it helpful for doctors to provide additional information on the type of work they usually conduct (86%) and whether they have any specialist qualifications or professional interests (85%). Having a photograph of a doctor was considered the least helpful of all the types of information tested (49%).

As part of their engagement with stakeholders, our Regional Liaison Service found that the categories of information to include on the register which received the most support were: scope of practice; credentials; languages spoken; employment history; declarations of interest. They found that some patients were supportive of adding further information on qualifications, experience and scope of practice, as well as practice location. Yet patients noted that they will often use google or practice website to search for information, commenting that a large amount of tier two information is available elsewhere. Patients highlighted the difficult in searching for doctors on the register but were against the idea of publishing photographs. They felt this would not be necessary and would impact on doctors’ personal safety.

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

This question gave respondents the opportunity to explain the reasons why they don’t think that the additional information should be included on the register. 3276 (42%) respondents provided a response to this question.

Respondents said the additional categories were unpopular for a range of reasons. Of all of the categories of information that were suggested could be added to the register, the inclusion of photographs and links to feedback websites were by far the categories most frequently commented on. This was reflected across all categories of respondent, including patients. The Patients Association said ‘from the supporters surveyed for this consultation response, photographs were the main category identified as ‘shouldn’t attempt to collect’, this was followed by a link to recognised feedback’.
Unnecessary, burdensome and costly

132 Respondents said that the additional categories were unnecessary, burdensome and costly to introduce and maintain. Many doctors said they would be angered if their fees were spent this way. Many said the benefits were not adequately described to warrant the cost and burden of the inclusion of new categories. The PSA commented that the ‘benefits of [the] two tiered register and other benefits to public protection in providing other categories of information [are] not demonstrated’. Some highlighted the fact that patients cannot choose their own doctor in the NHS, therefore the information had little benefit. One consultant said ‘...patients in the NHS do not ever have any say in which surgeon they are referred to. The NHS does not provide this choice to patients’.

Changing the purpose of the register

133 Many respondents said that publishing this kind of information was not in keeping with the purpose of the register, to define whether a doctor is registered to practice. A number also thought we were supporting privatisation of healthcare. They felt we should limit the information we publish on the register to information required to be published by the Medical Act. One doctor said ‘If I wanted to advertise my private services then let me pay for that. This is not the remit of the GMC’. Another said ‘All you are attempting to do is create a catalogue of doctors and drive towards a style of healthcare more similar to private healthcare’.

134 Respondents were concerned that the additional information would turn the register into an ‘online CV’ or a kind of ‘Facebook for doctors’. Linked to this was the view that this information was already available elsewhere. It was frequently noted that many doctors already share this kind of information on other websites and that they do so at their discretion. This would mean duplication of information on practice websites and NHS Choices.

Rights to privacy

135 Many respondents said that publication of this information was intrusive and a breach of privacy - ‘it violates my right to privacy’. There was a very strong view that doctors did not want their personal data published online. Publishing some of the information will create safety risks for doctors and their families, as well as increase to risk of identity theft. This was particularly true in relation to employment history, location of practice and photographs. Many doctors mentioned risks of stalking and harassment and one GP said this was ‘more likely to occur to females with photos I should think’. The British Army in particular highlighted that inclusion of practice location would be a big difficulty for military doctors. One doctor said ‘Practice location and a link to place of work allow easy cold calling for advertising to individuals, or worse, facilitate impersonating a doctor to intrude into sensitive systems as they make stories more plausible’.
Potential to discriminate or disadvantage groups of doctors

136 A significant number of respondents raised the potential for some of the information to be used to discriminate or disadvantage certain groups of doctors, and advantage others. In particular, languages spoken and a photo could encourage discrimination on the basis of ethnicity, religion and age. For example, a doctor in training said 'given recent events such as an increase in racist attacks and the recent decision to reduce the number of doctors by the current health secretary, by defining and classifying a doctor by what they look like, you could be opening up the doors to even more judgment by the colour of someone’s skin or where they are from - neither of which should matter at all'.

137 Doctors could be disadvantaged by publishing practice history that demonstrates they have changed roles frequently or taken breaks in practice such as maternity leave. The Medical Defence Union said ‘There is also a concern that inappropriate inferences may be drawn by some from employment history – for example that of a doctor who has moved around and undertaken many posts, or even of a doctor who has held the same post for many years, or a doctor who has unexplained gaps in employment or worked abroad for a period of time’.

138 Some respondents also highlighted that some doctors could gain advantage by putting this information on the register. One consultant thought that doctors with commercial interests and individuals engaged in private practice could be advantaged by the inclusion of the above categories, as well as... ‘photogenic, white, self-promoting, non-EU (post Brexit), non Black and Minority Ethnic (BME) doctors, particularly if well-connected/privileged (because the nature of each professionals' social and professional milieu will be indicated by the level of detail in the social media and review site level detail you seem to propose)’. The Royal College of Psychiatrists highlighted that additional information ‘...could end up being a tool for promotion of services and sway patients more toward choosing the doctor with the most complete profile, rather than the doctor who is most appropriate’.

Accuracy of the information

139 Many respondents said that it would be too difficult to ensure the accuracy of the information or to keep the information up to date on an ongoing basis. Therefore it would diminish the registers reliability and reputation as an up-to-date, robust data source. In relation to employment history, some said it would be disproportionately difficult for doctors in training and locum doctors to upload and keep up to date with frequently changing posts, which could also be negatively misinterpreted by patients. Language proficiency was another area highlighted as difficult to verify. The MPS said ‘Inclusion of additional categories complicates matters and [it would] lose [the] status of [the] register as robust and reliable, up to date reference source’.
A small number were concerned that a failure to upload accurate information by the doctor would lead to fitness to practise investigations being carried out against them for dishonesty, even if done by honest mistake.

Links to recognised feedback sites was one of the main categories respondents commented on. They felt that including this invalidated information on the register would inappropriately legitimise the feedback on the sites or will be seen as endorsements by the GMC. Respondents felt strongly about the subjective nature of the feedback, with many highlighting that patients only gave feedback when they weren’t happy with the outcome of the consultation, for example being refused antibiotics or sleeping pills. One GP suggested that 'If you propose to include this sort of review surely you should also provide peer review/360 MSF/Patient satisfaction questionnaires, which are more likely to be balanced accounts of a doctor’s practice?’

Some respondents raised the risk that the additional information could confuse or mislead the public. For example, one GP said ‘Languages: I speak 3 others conversationally but would not want patients to visit me expecting medical level of communication in said language’. Many also said that the additional information would not be of any benefit to patients. One respondent said ‘The fact that doctor A can speak 7 languages or has 20 letters after their name bears no link to them being a better/more caring/ more trusting doctor than doctor B who speaks one language with their sole medical degree’.

Some categories of information were considered too vague and required additional definition. In particular, scope pf practice and credentialing were not well understood by the few people who commented on them. One respondent said ‘Scope of practice is too vague and is almost certain to overgeneralise to an extent which could be misleading for patients. Scope of practice was seen to be something ‘dynamic’ and ‘highly individual’. However some did provide comments in favour of scope of practice information such as ‘Special knowledge regarding autism and disabilities pelvic radiation disease training completed in the above areas’.

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

1652 (21%) respondents provided comments in response to question 11. The significant majority of respondents did not suggest any additional information (beyond those already suggested in the consultation document) to be included in the LRMP.

Comments against additional categories of information to include on the register

The vast majority of comments received cautioned against including other categories of information on the register. ‘The MDU generally uses the GMC register only for the purposes of identifying individual doctors. When seeking any other information about
doctors, staff members asked said they use a search engine which usually provides links to relevant information through the doctor’s employing organisation(s) or practice(s) and/or academic institution’.

A large number of comments stated that the register should be kept to an absolute minimum, and questioned the purpose of expanding the register. One consultant said ‘It is a GMC register. Therefore the only data relevant is GMC stuff. When did you get registered, what is your registration status, is there a specialist registration? Most of the rest of the data you want has nothing to do with the GMC’.

A number of respondents said we could improve the current register. For example, one consultant said ‘What you have now is sufficient and perhaps you could simply improve it with for example plain English explanations of what qualification abbreviations mean, and perhaps links to Royal College websites and support resources…’

Additional categories of information that might be useful to include on the register

A very small number of respondents made suggestions about other categories they might find useful to include on the register.

12 organisations proposed additional categories of information. Their most common requests were for further information on special interests or sub-specialties, including recognition of trainer status (when legislation allows), teaching status and membership of advisory boards, faculties or health charities. A small number of also requested additional details on revalidation, notably revalidation dates and completed annual appraisals.

13 members of the public made suggestions focused on three areas more detail on historical fitness to practise cases, additional details on the location and nature of the registrants' employment (including involvement in private practice, out of hours practice and charitable activities) and additional details on scope of practice (clarification on the scope of an individual's responsibilities and their areas of specific expertise). One member of the public said 'It is essential to include information about criminal convictions, cases of malpractice and negligence, and any disciplinary procedures against them. This should be included whether in the private sector or the NHS, and whether in the UK or abroad. It should also be noted whether the disciplinary procedures were properly concluded or not…..It must be easily accessible and readily available to help them if they had to bring a case against the wrongful practitioner.

Suggestions were made by a small number of doctors, doctors in training and medical students. These included: more detail on qualifications and stages of training; revalidation; employment and work location; scope of practice; areas of special interest, research publications and prizes/awards received.
One doctor in training said ‘...I do think that current area(s) of specialism would be more accurate and less misleading in the case of doctors who have made a clear career change and could no longer safely practice in a formerly recognised specialty’.

The three quotes below are example of suggestions received from consultants.

‘There should be details of any specialist areas that do not fit the current areas of registration - for example spinal surgery. Currently spinal surgeons do not have any specialist field on the register yet we do have the ability to be employed in the NHS as a pure spinal surgeon from either an Orthopaedic or Neurosurgical training background’.

‘Place of training actually - it is important for patients to know whether a doctor has trained in the UK or not. Being registered with the GMC does not mean one has obtained their qualifications in the UK and training, as we know very well, is extremely variable across Europe and the world and impacts on how we practise’.

‘where extra income is obtained for professional services, e.g. pharma, immunisation companies, consultation fees etc’.

In addition, we received one comment recommending closer integration between the GMC register and NHS Choices website

‘...The Patients Association recommends that staff listed under a practice on the NHS Choices website are better connected to the GMC's medical register as currently just a doctors’ GMC number is listed and this requires patients to understand how to search and use the register. By better integrating the GMC register and the NHS Choices website, the Patients Association believes that the public would have greater awareness of the register and the register would better promote and maintain confidence in the medical profession’.

A number of respondents suggested the inclusion of information already present on the register, or information already suggested in the consultation document.
Question 12. Do you agree it is sufficient for Tier 2 information to be subject to verification through sample audit, provided the status of the information is made clear to those consulting the register?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
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</tr>
</thead>
<tbody>
<tr>
<td>All respondents</td>
<td>952</td>
<td>2574</td>
<td>913</td>
<td>3302</td>
</tr>
<tr>
<td>Organisations</td>
<td>17</td>
<td>25</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>Doctors</td>
<td>554</td>
<td>1404</td>
<td>523</td>
<td>1561</td>
</tr>
<tr>
<td>Members of the public</td>
<td>22</td>
<td>17</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>All other individuals</td>
<td>35</td>
<td>32</td>
<td>13</td>
<td>759</td>
</tr>
</tbody>
</table>

155 952 (12%) agreed that it was sufficient to verify a sample of tier 2 information, provided the status of the information was made clear to those consulting the register. 3302 (43%) respondents did not answer the question. 1934 (25%) respondents provided comments in their response to this question.

A sample audit is not sufficient

156 The majority of respondents across all groups said a sample audit was insufficient verification. Most comments can be summed up by the following statement by a doctor in training - ‘All of it should be 100% accurate and verified’. Another doctor said ‘If one of your overarching principles is to be able to validate this information, a sample audit is insufficient’.

157 The main concern was that the information on the register would not be accurate if all of the information was not verified. The GMC register is relied upon as a trustworthy source of information. For example, one consultant said ‘I don’t think audit is enough as the GMC is a trusted brand’ and a doctor in training said ‘Sample audit is not good enough. It has to be every detail posted on the website. The GMC is the only body trusted fully by patients, too trusted for you to leave things to chance that you may catch out falsifications through sample audits’. A member of the public said ‘no information should be included without direct verification, sampling is completely unsatisfactory and risks consequential errors in published information’. Respondents noted that the GMC is a highly regarded regulatory body and there is public expectation that information provided on the GMC website is accurate and validated. It would be unrealistic to expect the public to understand the implications of information only being checked by sample audit.

158 Respondents were concerned that a sample audit would provide false assurances to members of the public that all information is verified by the GMC. One medical student said ‘I believe that when the public are looking for information on the GMC medical
register they should be assured it is accurate and verified and there is limited value of additional information that the public have to judge whether it is accurate or not’.

A number of respondents highlighted the potential risk to patients if inaccurate information is on the register. One doctor in training said ‘If only one mistake is found and leads to patient harm the press will have a field day with the story!!’ A member of the public said ‘No, everything must be checked and verified for every member listed. There cannot be any room for error when patient safety is at risk’.

Respondents commented that sample audits do not guarantee the accuracy of the information, which may result in some doctors who provide false information never being identified. If tier two information is voluntary it is likely that only a small number of doctors will contribute information, in which case auditing a sample of the information is of limited value.

Some respondents questioned the value of auditing voluntary information. One GP said ‘If it is voluntary then why does it need auditing?’ A doctor in training said ‘Since it is voluntary information, the process of verification should not cost anything (in time, opportunity costs or monetary costs) for the doctor concerned’.

Cost and burden

A significant number of respondents said that a sample audit would create additional burden for doctors and increase their workloads. Doctors in particular questioned an increase in their fees to cover the cost of this exercise and felt it was unfair for doctors to ‘shoulder the burden’ of a sample audit. One doctor in training said ‘Doctors already have enough form filling and bureaucracy to content [sic] with without this’. A number of responses from members of the public also questioned the additional burden on doctors ‘This all just sounds like unnecessary burden on doctors’.

General opposition to having additional information on the register or a two tier approach

Many respondents re-iterated that they do not agree with putting additional information on the register. Their reasons are set out in response to earlier questions in this report, but include the cost, the purpose of the register and privacy and safety issues. Many respondents also voiced their opposition to a two-tiered structure for the register. Again, the reasons provided have been set out earlier in this report.

Those who agreed it could be useful

A small number of respondents did agree that a sample audit would be useful; although not all were convinced it would be sufficient to ensure accuracy. Some organisations said it might be helpful in assessing the functioning of a two tiered system, but will not identify those who may misuse the system. One consultant said ‘It would be idiotic of a doctor to present incorrect/inaccurate information on a GMC audited website’.
A number of respondents also highlighted the need for a process for someone to question the accuracy of the information. One GP said *There should be a function for the public to alert the GMC if they believe any tier 2 information given is misleading or untrue*. Another GP said there should be a whistleblowing option if they spot a colleague’s inaccurate entry. A member of the public said ‘*There should be an easy way for anyone searching the register to log a query concerning information found to be inaccurate or out-of-date*’. Some also asked how we would distinguish between mistakes or intentional provision of misleading information.

*Suggestions to better verify the information*

Some respondents suggested additional ways to verify the information. These included: declarations; annual returns; independent validation; email prompts; clear sanctions for false information; a statement of when the entry was last updated or verified.

*Question 13: If you’ve used the online register, do you have any thoughts on how we can improve it and make it more user friendly?*

2002 (26%) respondents provided comments in response to this question. The significant majority of respondents either chose not to comment or declared that the register was acceptable as it was and should not be changed.

Many felt that the online register was already user friendly, that the proposed ‘benefits’ of the changes were disputed (with questions raised over the credibility of the research), and that the changes could represent a risk to privacy and individual safety. One consultant said *Patients who want to search for certain specialists in a certain locality can quite easily search the directories of their local NHS or private institutions. There is no need for the GMC to add this information as it is already in the public domain. Furthermore, as doctors frequently move practice/hospital then this information may not be up to date*.

Most of the recommendations provided in response to this question were about information that could be displayed on the register (echoing responses to the other questions in the consultation), as well as the usability of the entire GMC website rather than the register.

Recommendations to improve the register tended to fall into three main themes – improving the search function, simplifying language and improving the layout and navigation.

The most popular response was related to access to the register. Respondents stressed that the information should be easily accessible and understandable, and that patients should be made aware that they are able to access this information.
Improve the search function

172 Recommendations to improve the search function included introducing the ability to search by specialty and location, as well as what the person is 'known as' and what the person’s name 'sounds like'.

173 One doctor in training said ‘It would be useful to be able to specify specialty. I occasionally need to find GMC numbers for colleagues and having to root through 200 entries for John Smith is infuriating when I know they work in a small specialty’. Another doctor in training said it would be helpful to search for a maiden name. ‘I previously worked under my maiden name and anyone searching for me under that would find no record of me currently online’.

174 The Medical and Dental Defence Union of Scotland (MDDUS) said ‘...some doctors practice under colloquial names - either by first name (e.g. 'Dr Sam') or by a contraction or abbreviation of a long surname. It is difficult to search the LRMP unless the full registered surname is known. This can be made difficult again where the surname may be such that there [are] a variety of spellings. The 'sounds like' option currently available is helpful, but only of limited use. Perhaps this facility could be enhanced’.

175 One member of the public said 'It would help to have a wider variety of search parameters, e.g. hospital name and department, as an alternative to only the doctor's name or GMC reference. When a patient does not know the doctor's full name or its correct spelling, there has to be an easier way to find the correct profile on the register'.

176 However, a number of respondents also expressed concern at proposals to amend the search function. In particular, there was a concern that this may facilitate the identification of potentially vulnerable doctors – including those working in high risk specialties (forensic psychiatry) and those working within the military.

177 RAF Medical Services said ‘Allowing people to search for a doctor by local area and qualifications will compromise the security and safety of doctors if the person searching wishes to do them harm e.g. doctors who are GPs with a specific set of diplomas (such as Dip Av Med and DMCC) are likely to be from a military background’.

178 A doctor in training said ‘...But if a doctor has been the target of a crime and legitimately needs to move away, they are either penalised for not listing their location, or they are immediately findable... Extreme care needs to be taken when designing the search engine to avoid disadvantaging doctors from vulnerable minorities / making them the easy target of hate-crime’.

179 A number also felt any attempt to improve the search functionality of the website would not be compatible with the GMC’s remit, particularly when this information is already held in the public domain or available elsewhere. For example, one doctor in
Clarify and simplify language

180 Recommendations to clarify and simplify the language used on the register included making sure that lay terms are used wherever possible, with abbreviations (and doctor’s grades if introduced) clearly explained.

181 The Christian Medical Fellowship said ‘Making it clear what ‘registered without a licence to practise’ means would help both patients and organisations using the register. Doctors working overseas usually have to relinquish their licence. Although the licence only relates to practice in UK, some users may think that a doctor without a licence is not fit to practise, whereas they are actually in good standing but have temporarily relinquished their licence while working outside the UK. This confusion may prevent doctors from getting registered in other countries, or may reduce the confidence patients have in them. Two small changes would help: 1. Adding ‘in UK’ to the label ‘registered without a licence to practise’. 2. Adding an explanatory note: ‘Registration without a licence to practise means that the doctor is in good standing with the GMC but not currently licensed to practise in the UK’.

182 Members of the public in particular requested additional detail about the areas of practice doctors are legally and professionally competent to practice in, providing details of qualifications, explanations of abbreviations and explaining why doctors might be suspended.

183 One member of the public said ‘Just to make the whole thing transparent to all and any information to be made easy to access this, together with a breakdown of what a Doctor, Consultant is legally, professionally and qualified to carry out’.

184 A medical student said ‘…Perhaps it would be useful to have a small blurb or pop up to explain what the different grades of doctor are. Or perhaps you could click on the doctors position (e.g. - ST3) and it would explain exactly what this means so that the public can be in no doubt’.

185 Respondents to the Patients Association survey stressed that the information should be easily accessible and understandable, and that patients should be made aware that they are able to access this information.

Improve layout and navigation

186 Recommendations to improve the layout and navigation of the site included reducing the number of clicks required to access relevant material, reducing the number of ‘pop-up windows’, and giving the register given a more prominent location on the GMC home page. Consideration of the amount of text and font size was also suggested. Some also suggested tailoring the availability of the information towards the audience.
with different levels of information available depending on whether someone is a member of the public, an employer or a doctor.

187 On consultant said 'The register should include options to change the text size/contrast etc and include dyslexia friendly fonts. The pages and entries should zoom in properly and also the colours should be clear with well defined borders. Finally it should include the option to change languages of the buttons perhaps?'

**Conclusion**

188 Respondents to the consultation demonstrated a clear lack of support for the options put forward for developing the online medical register, and nearly all respondents objected to adding further information to the register. This was despite the independent research in 2015 having indicated a consensus for at least some changes, and feedback through other engagement demonstrating an appetite for improvement.

189 Most respondents wanted to limit the purpose of the register to providing assurance to the public that a doctor is registered and licenced to practise medicine in the UK. They did not see the GMC as having a role in providing the public with additional information.

190 There were clear concerns raised by respondents. The main concern was related to doctors’ privacy and safety. While some of these comments were based on a misunderstanding that we were proposing to publish sensitive personal data, they demonstrate the strength of feeling among respondents.

191 We recognise the importance of balancing openness against the individual privacy of doctors and understand the concerns raised by a large majority of respondents about additional information potentially having a severe impact on their safety and privacy. For the avoidance of doubt, however, we have not proposed to publish any private or sensitive personal data and the options presented related only to doctors being able, voluntarily, to include information relevant to their professional roles.

192 Respondents also raised concerns about the potential for additional information to disadvantage some groups of doctors or promote discrimination, as well as mislead members of the public.

193 Challenges around the practicality of the proposals were another cause for concern. In particular any cost of amending the register, the difficulty of keeping the information up to date, and the risks of information not being accurate. It’s worth clarifying that none of the options presented would have impacted on the annual retention fee.

194 These views, coupled with the volume of responses received, demonstrate the need to exercise caution before deciding to introduce any further changes to the register. At this time, we will not take forward these options to enhance the register.
We will continue to develop our plans for credentialing following the positive outcome of our consultation in 2015. We will also work with the Academy of Medical Royal Colleges to explore the desirability and practicalities of collecting and possibly recording information about doctors’ scope of practice. However, we would take on board feedback from this consultation before making any decision to proceed further.

As part of phase one of our digital media strategy, we are intending to do work to improve the look and functionality of the LRMP. The helpful suggestions provided in response to the consultation will help to inform this work.