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Public repository of consultants' practice details should include competing interests

Cyril Chantler explains why a public register should include doctor's competing interests and be overseen by the GMC

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"Patients must be able to trust doctors with their lives and health." These are the first words in the Duties of a Doctor by the General Medical Council (GMC). In February 2020, the Independent Inquiry into the Issues raised by Paterson was published.¹ Chaired by the Right Reverend Graham James, the comprehensive report detailed the lessons to be learnt from the patients injured by the surgeon Ian Paterson who was jailed for 20 years in 2017. Many of Paterson's patients spoke about how their experience had caused them to lose trust in their doctors, "knowing I was deceived and betrayed by a medical professional who should be totally trustworthy."

Issues concerning lack of trust were also reported to another inquiry into harm from medicines and medical devices. The review, chaired by Julia Cumberlege, published its report "First do no Harm" in July 2020.² It looked into harm related to three separate treatments: hormone pregnancy tests, mainly the drug Primodos; the use of the anti-epileptic drug sodium valproate during pregnancy; and the use of pelvic mesh for stress urinary incontinence and pelvic organ prolapse. One of the women injured by surgical mesh told the review team, "As patients, we allow the medical profession access to our bodies, our thoughts, and our lifestyles. All manner of information to better assist them in reaching decisions about the best course of treatment for us. We, the patients deserve the same, we should be aware of clinicians' allegiances or involvements whether they be financial or other. So we too can reach informed decisions about who is best to treat us, and how they should treat us."

Concern about conflicts of interest is not confined to the UK. A paper from the USA Institute of Medicine in 2009 said there were significant risks that individual and institutional conflicts of interests were unduly influencing professional judgements, and that such conflicts, "threaten the integrity of scientific investigations, the objectivity of medical education, the quality of patient care and may also jeopardise public trust in medicine."³

The Cumberlege review made a specific recommendation that the register of the GMC should be expanded to include a list of financial and non-pecuniary interests for all doctors, as well as doctors' particular clinical interests and their recognised and accredited specialisms. During the oral hearings of the review, and subsequently, there has been support for this recommendation from medical royal colleges and by others, including *The BMJ*.

The UK government has now responded to the recommendations of the Paterson inquiry and has committed, in principle, to creating a single repository of the whole clinical practice of consultants across England, setting out their practising privileges and other critical consultant performance data—for example, how many times a consultant has performed a particular procedure and how recently.⁴ This repository should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and the independent sector. The main emphasis here is on the collection of data about consultants' clinical work, and alignment between the NHS and the private sector of Hospital Episode Statistics. This can then be used to see both the activity, and in due course, the outcomes to improve quality. The response also discusses how this information can be used in annual appraisal and revalidation of doctors. How this is to be done requires further thought and work, but the recommendation is to be welcomed. It should also be expanded to include doctors' commercial and other interests.

While the Paterson report does not explicitly discuss how to improve trust or the GMC's role, it does recommend "that the Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry."

Between 1994 and 2004, I was a member of the GMC and chairman of the standards committee. I was also the vice chairman of the "First do no harm" review. My opinion is that GMC already works with others to ensure the professionalism of doctors and to keep patients safe. These others include employers in the NHS and private providers. In my view this is the way a clinicians' conscience and contract work together to serve patients. The GMC maintains the register of qualified practitioners—indeed that is their main function. This register is available for inspection by the public. The GMC also establishes standards of practice, as set out in Good Medical Practice, and by working with the specialist associations the GMC develops and maintains the specialist register. The process of appraisal, with revalidation as appropriate, is an example of how the GMC works with others, such as employers, the private sector, specialist associations, and colleges.

We can apply these considerations to the question of how we might create, maintain, and use a register of interests, as recommended by the Cumberlege review.

The GMC must, in my view, be responsible for repository and it should be mandatory. The public needs one place to go to to obtain information which I believe it is their right to have. But the GMC need not do it on their own; employers, the private sector, the royal colleges, and others need to help. It should be organised around the appraisal system. Each doctor would need to complete or update one form, and only one form, each year. The form would be checked and validated by the appraisal process both in general and specialist practice and then lodged with the employer, contractor, private hospital, or clinic—as appropriate. The public could access this information either directly from the provider’s website, or from the GMC, via a link. This would be an administratively simple, quick, and effective way to improve transparency and begin to rebuild trust.

Competing interests: CC is non executive director Private Health Information Network (PHIN), adviser All Party Parliamentary Health Group “First do no Harm,” vice chair of the Independent Medicines and Medical Devices Safety Review, 2018-2020.

- 1 The Right Reverend Graham Jones, Report of the Independent Inquiry into the Issues raised by Paterson, February 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf
- 2 Cumberlege J. First do no harm: the report of the Independent Medicines and Medical Devices Safety Review. 2020 Jul 8. <https://www.immmsreview.org.uk/Report.html>.
- 3 Lo B, Field MJ, eds. *Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice. Conflict of Interest in Medical Research, Education, and Practice*. National Academies Press (US), 2009.
- 4 Mahase E. Government commits to public repository of consultant details “in principle”. *BMJ* 2021;375:n3115. doi: 10.1136/bmj.n3115. pmid: 34920993