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Lynn Eaton: Why do you think the revalidation issue is possibly the biggest issue that has happened in the medical profession since the GMC started?

Niall Dickson: Revalidation is the biggest thing that has been attempted in the last 150 years for regulation and it will change the relationship between the GMC and the profession and I hope in a really positive way and it should move us away from being seen as the organisation that collects some money from people once a year and then maybe one day knocks on their door and says something nasty to them. We do not think we are that kind of organisation already and for the vast majority of doctors we are not but revalidation will certainly, I hope, make us the organisation that really does assure your competence with Fitness to Practise. At the moment the register is a record of qualification that is not an indication it's a historical record qualification its not a contemporary or near contemporary record of new competence in Fitness to Practise and I think that is a great goal which we are seeking to achieve to make the register more relevant to give great assurance to the doctors to employers and to patients and the public and I hope that it will encourage more self reflective practise within the profession.

Lynn Eaton: Why do think that changes are important to the profession.

Niall Dickson: Well I think it's important due to patience and the profession. The fact is that medicine today is more powerful, more effective than it has ever been. It is also potentially more dangerous and giving individual doctors the assurance of their competence in Fitness to Practise and giving that assurance to the public seems to me an essential compared to the modern regulatory system if at the moment all we are saying on the register is as soon as someone passes the exam or completed the course some years ago and I am not sure in the modern complex that sufficient is good but its not sufficient and as we take it forward. I hope that having said all that and recognised that this is a big thing and 150 years to the General Medical Council, that one also has to we are not really expecting anybody to do anything that they should not be doing anyway. Revalidation itself is only a recognition or should be only a recognition of good local clinical governance arrangements and the health service for example has committed itself to having good medical clinical arrangements for many years reality is they are not always there the ? and the country and what we hope with revalidation will do is stimulate the system to put in place good local clinical governance arrangements which are really important in terms of assuring the running of a good service. And I try and question the other way and say to those who are running healthcare institutions do tell me what in terms of good clinical governance you should not be doing. Should you not have an assurance that all the doctors who are working in the organisation are competent to Fitness to Practise should you not be supporting these doctors to keep them up to date, should you not be providing them with the necessary support if there are areas of their practise that they need to develop.

Lynn: So you are putting some of the elements on the employer as well as yourself as a regulatory body?

Niall: I am putting quite a lot of onus on the employer, am putting quite a lot of onus on individual doctors and am putting quite a lot of onus on us, I do not think this is a ?, we have to recognise that this is going to work in the ?, individual doctors and to reflect on their practise and to help gather evidence over a period of five years which absolutely requires employers to provide support in the gathering of that data and development if development needs to be identified during those five years and it requires that to get the model right to make sure its not too costly and not too burdensome. So we all have something to do here.

Lynn: So coming back to the actual detail of how revalidation, I do not quite get how we get into that gesture as I would like to keep a board of who should go if they could. We touched initially on the fact that you have had already two sorts of headline stories one of which was the out of hours case and you made a very strong statement about the climate for appropriate language skills and it surely makes sense for doctors to be able to at least be proficient in English if anybody working in this country. We are also picking up on the fact that you then said the elements was on the employers. Can we just get a view how you see the role of the employers in this next five years.

Niall: I did not say the onus was on the employers in the sense that it is no onus on us. I think what I was recognising first of all is that there is a gapping hole within our registration system as a result of combination of EU directives and our own Medical Act which means that the doctors who come here from the European Union are able to get onto our register including the specialists parts of the register without us being able to check not only their proficiency in English but also their competence to practise. So I can not provide any assurance about those doctors. They may be good; in fact I am absolutely confident that thousands of them are working very safely and effectively in this country. But I can not give that assurance so what I am saying to employers is that we can not provide that assurance because the legal framework is not there but that in any event and especially when we can not give that assurance, the employers have a duty when ordinary contractors who are contracting with the organisations that take on and employ doctors that they have a duty to ensure that the doctors who are operating or treating patients as a result of that are fit for the purpose as well as fit or practise. So, the fact that somebody is on the register whether EU graduate or not does not remove from employers the need to assure themselves that doctor is competent and fit to practise, and the register as I have pointed out there before causes a historical record it tells you that somebody passed an examination on a certain date, it tells you that they completed the courses on a certain time. It does not necessarily tell you two things it does only with their competence to fitness to practise at the moment and it certainly does not tell you whether they are competent to fitness to practise in a particular job that you are employing them to do and that is very much an employer's responsibility.

Lynn: What are you going to do to try and push for greater powers to check for language skills in the GMC's ?

Niall: Well I think our ? for both in term of language skills and competency in fitness to practise and we will be having discussions with the government now and we will be keen to have those discussions. We want to press the UK government for changes in the Medical Act here and along side that we want to press for changes in Europe. I think it is easy to simply describe the European Union all around as being completely blind they are not interested, they are only interested in free movement of labour. We believe and from early discussions that there are certainly at the political level within Europe people who are interested and who recognise that there is a difference between allowing free movement of labour among the European Union and the issue of patient safety, and patient safety should triumph the question of free movement of labour and so I am not saying that we are going to achieve some victory on this but we are very determined to be on the front foot to work with other regulators in this country and across Europe to try and get a better system which provides more assurance about the safety of doctors who are moving around the European Union.

Lynn: Do you feel up until now that employers have taken sufficient ?

Niall: I think the issue that has emerged recently has been around the performance list that has operated and I think the government, the department of health has pointed out that it has not been operating as well as it should be operating and I think it is important that employers understand their responsibilities. It is also important actually today to understand our limited ability to control doctors coming on to our register from the European Union.

Lynn: The other one I want to touch on again is the Jane Barton's case I do not want to get into the details of that but obviously because of that the GMC has started being seen as protecting it's own rather than protecting the public. How will you change that impression whether or not you feel that is a fair allegation to make against the council?

Niall: GMC thinks it is a fair allegation to make against the council remember of course today's council is 50% lay and 50% medical and I think it would be unfair on medical members of council as much as it is on the lay members of council that they have any other purpose other than protecting the public we have to work with the profession to achieve that but that is our objective. As far as the Barton case is concerned, we made a comment after that judgement to the effect that we were surprised of the panel's decision that we had, as the GMC called for erasure and that we would reconsider our position. And some of the press are surprised about that because they see what happens when you criticize yourselves and the answers is of course we have to at the moment two functions with the Chinese wall within one organisation. On the one hand we are the organisation that brings the case, presents the case to the panel and as part of that we ? what we ? As an organisation is the appropriate function. The panel which has ? autonomy that is legally appointed by me but is an autonomous body that has the right on the basis of evidence they hear to reach their own conclusion about the sanctions required

and there are arrangements at the moment whereby CHRE can decide whether it wished to appeal any decision that it thinks is inappropriate.

Lynn: Sorry CHRE meaning?

Niall: The Council for Healthcare Regulatory Excellence it's a panel. That will change next year. It's really important this and that is going to change next year because we are losing our adjudication function so our role when the new body is set up will be as now to present the case but I will no longer be responsible for organising or appointing the panels and this is an awfully long way from the days in which members of council sat on panels or members of council actually screened cases. That does not happen now; the council is a strategic body responsible for setting the strategy of this organisation from monitoring the executive and holding us into account, it's not involved in the day to day running or the deciding of the individual

Lynn: Who then is going to doing the adjudication?

Niall: It is an organisation called OHPA which is the Office for the Health Professions Adjudicator. They may well change their name but that is what they are called at the moment and so we are handling that function to them. The point is that in this statement that we made in relation to the Barton case in one sense we were signalling what the future would be and the future will be if we, and this will not be a daily weekly, maybe not even a monthly occurrence that where we think a sanction that has been issued by the panel is inappropriate, it will be the GMC that has the power to appeal to the High Court and in a sense although there is a Chinese wall at the moment which we were taking advantage of to say well, where we disagree. And in a way we were re-enforcing the power of the panel because the panel is autonomous, they make their own decisions and we did not criticize the decision we simply expressed surprise and said that was not what we had called for on the basis of the evidence that we have collected, what we have presented to the hearing and what we and our legal team had heard from the other side we thought it was an inappropriate sanction.

Lynn: But to come back to my original question, you have explained that I ? in future that may

Niall: As far as this case is concerned I hope that explaining what is at doubt here which is a reasonably complex situation and the fact we were not in our statement I have to say, trying to appease public opinion we were trying to reflect what we thought was the right outcome on this particular case. I do not think it is our job to appease public opinion. Our job is to run an efficient and fair system of fitness to practise which certainly holds doctors to account which does not punish them we are not a punishing, there is no punitive element to ours, we simply have to reflect what is the appropriate sanction for a)protecting the public and b) retaining the confidence and trust of the public to the profession that is the nearest bit to appeasing the public but I don't think it is about appeasing the public opinion but it is about what will maintain confidence and trust in the profession.

Lynn: Just to continue this line of enquiry, I mean everybody sees it's a widely held view that the BMA towards agencies to its relevance, is the strongest union still left in this country after perhaps the National Farmer's Union that doctors as a profession are incredibly powerful and have been reluctant to open up their books for people to see what they are doing. How do you think, how the union like the BMA is going to affect the revalidation processes ahead, do you really feel they signed up to, or do you think there are going to be some hiccups on the way?

Niall: The BMA certainly tells me that they are signed up to it, they absolutely support the principle where I think there are worries about how this thing will be implemented and I think they have concerns about the financial squeeze that is coming and whether as a result of this there really will be the support that they think is really necessary to make revalidation a success. I hate that we have stayed together on this journey and I think it's important that we do and that the BMA will go on providing strong membership in this area and time debunks under the myths that are aware. A lot of the myths are around the idea that this is what might be called a fifth year process over a five year process so people think that after five years some big interview will take place or somebody will sit down in an exam and say you failed you are off the register. It is not going to be like that, it is a five year process, that means that what we expect to happen is that somebody will, or a doctor will have their appraisal after year one, they will produce some evidence of their competency in their fitness to practise. If there are areas where which you know, they have not got the evidence or they need to get some more evidence or there is an area of their practise which needs development they need to address that then so if you like the green lights that should be given all along the system. There is no surprise in year five that nothing is going to happen, the only thing that will happen in year five if you have done four years of preferably good green light appraisal is that the thing will be taken and you will be off. You will not even notice it. It is a base. And if something does go wrong in year one or year two lets say and if most things will be about saying well there is a bit more you can do there or there is a little bit of concern about this, why are your results a bit outside the normal zone. This will be addressed at local level or to be addressed by the doctor himself or addressed within a court or addressed by some kind of other ? support and so on. So we are not talking about big remediation or about the doctor being taken off somewhere for something funny to happen. Of course there maybe this process may fair up a very small number of doctors who are a really serious problem. I have to tell you that has got nothing to do with revalidation its to do with what should be happening anyway and if that throws that sort of thing up, then there are things that may be done locally or they maybe referred to NKAS or if it's a really serious affair where the impairment practise was really affected, then a referral to the GMC but that is not different from what should happen now, revalidation would only be linked to that in the sense that an institution had proven in place good clinical governance arrangements which frankly it should have in place now. And the additional bit that we are putting in so called the enhanced appraisal rears two elements; the first is that we are marbling through good medical practise which is our core document which sets standards for medical professionals in this country. So that will apply across

the whole country that's in the sense our date, our intellectual bit into this process and then the other bit that is being added is the equal college and faculty within each speciality is putting in their particular elements that they think are things that are needed for you to demonstrate if you are a GP that you are competent to fitness to practise. And it's those two things that make this sort of enhanced appraisal along with the 360 so that you should have at least across this five year period some reflection of what your colleagues think of your practise and what your patients think about your practise. Which again to respond to the obvious question does that mean that if you know a couple of patients say because they wanted antibiotics they get one and they worry that it is difficult, no it does not mean that, no these two should be properly revalidated is not about being a strong impression upon them it is about understanding what will be best for you know the general medical practise ?

Lynn: Again playing the devils advocate, but people who are dubious about this will turn around and say to me well it would have never stopped Shipman and they have introduced it on back to Shipman. Why are we bothering then?

Niall: Because its not there to stop Harold Shipman. Harold Shipman was a serial killer. That's not what this is designed to do. I think there are issues about the collection of data and mortalities that this ? that a Harold Shipman case which you know might have spotted some things earlier if there had been better clinical governance in place. But let's not go there, that is not the purpose of this exercise. The practise of this exercise is to give assurance about competence of fitness to practise and to encourage doctors to reflect on their practise. And that's really good clinical governance arrangement should do. And largely it is a supported process which encourages people to do it and revalidation is after a period of five years kind of has it all been done great.

Lynn: It's a continuous assessment?

Niall: Yes it is

Lynn: Let's go down to the nitty gritty of how it is going to work as that seems to be thing that is bothering people. You are aware that the Royal Colleges and Faculties are going to be drawing up their own guidelines as to what is going to be placed and looking at surgeons for instance, there are actually quite a lot of plastic surgeons of high degree and very easy to monitor the ?. Talk me through how it is likely to affect paediatricians for instance, how are they going to actually be monitored day by day. What are they going to have to do in addition to what they already do that's not there?

Niall: And that is going to became clearer in the consultation when we publish the details from each of the special practises and remember that it is a consultation. We are not saying this is exactly what it looks like; the whole idea is that people will react and say I think its paediatricians we don't need to do this. I don't know why the Royal College is saying that or this aspect or that

aspect. So we want to absolutely hear people's views on that based on the build up of the generic framework that we have put in in relation to good medical practise and responses to the special ?. It's quite an early stage to process so we will print those when we launch the consultation process. You will see the detail of each of the specialties and faculties. In addition to that, once we have been through this consultation process we will then try out in some areas and see this stuff in the ? when you are in practise and then we will have to learn again from them about how well is it working, and what amendments need to be made before we then start to look at what organisations are ready to take this thing forward and then we will rule it there. It's not going to be a big bang it is going to roll out as organisations are ready but eventually we will expect every doctor whether working in the independent sector or the NHS or on their own or whatever to have a responsible officer who will sign off their five year period and enable them to reliance but it will take a bit of time to do that and it will take a lot of time for the organisations to kind of get their act together. Just one final point on this, there are places at the moment that are already doing almost everything that we are expecting so if you look at GP's in Wales for example, 90 something % of them already have revalidation, they have had an appraisal and an annual appraisal system, its common to the whole of Wales, it's linked to an IT system, they have to produce evidence of their copies of their competence and fitness to practise it is really quite advanced and the level of concern in Wales is much less this is because they are kind of already there. There are extra bits that we will put in in relation to the actual GP input and our enhancement through a good medical practise will not throw that system out of line it more actually just absorbs those bits and leave serious things towards the revalidation and am pretty confident that there are places where we can demonstrate that this is doable that GP's are not up on arms about it but there is general acceptance of not everybody loves this process, I mean let's be honest about it but is it something that means that they can't treat their patients because they are spending all their time doing this, does it cost billions of pounds, no. It does cost something that good clinical governance should mention. My argument is that you need to have them and you need them more than ever now there is squeezes on financially.

Lynn: Ok. I am interested that you referred to GP's. So the GP's are unawares, that people suggest is going to be harder ones to monitor and the infrastructure is not necessary so straight forward particularly in some practises but there must be some model whether it is an electronic sort of way of recording if you have been on a course that is part of your CPD, well some of those were already in place. Like if you do that course you get so many points

Niall: Sure.

Lynn: So that sort of infrastructure is there? Eluded to the fact that surgeons are perhaps easier to monitor than others but I would like to get a feel for it. You have mentioned GP's, I'd like to get a feel for how it would perhaps work in a hospital specialty other than in a surgery

where, how do you measure the outcomes and is it possible that you can be a good doctor but not have good outcomes?

Niall: You have to have. It's not all going to be an outcome for it because we would not have all the data to be able to do that. Maybe, in 10/15 years time, it might be it might be a good view once it's settled, you might say it's all outcome driven we have got this fantastic data base and all doctors are signed up to what this outcomes are and so, I think we are still quite a long way from doing that so where there is outcome data which we can use or some specialities and in some ways we are getting better at it. The health service in England for example, is currently trying patients supported to those outcome measures which are a major advance. Again, this sort of thing has been used by others like BUPA or portions of it for some years. And again in some areas it's easier to measure what you are doing so I don't think it's all going to be outcome based. The broad areas without going into detail, the broad areas are that the doctor will want to produce what CPD they had done and again there will be speciality specific, and stuff like that. They will want to have done a form of 360 which means multi source income and that's simply a survey which you know that will be done probably independently by a company of whatever who writes to a selection of their patients, selection of their peers, selection of their managers or whoever it is and then it is all collated and then the report is given back. And again, I think it is probably people are somewhat concerned about but I don't think it should really be a sort of, I think people get more anxious about it than it needs to be. And we need to make sure the tools that are out there that do this are valid measures of the fitness to practise so there is CPD, there is the sort of data around their practise which might be for example, you are surgical obviously what operations they have done what the result they have had and obviously if you applied that to somebody who ? and who wouldn't have a clue. So there has to be appropriate to [end of tape]

Lynn: It was suggested that this will defer from one speciality to another ? it is not very ?

Niall: I think those elements, some data and some multi ? feedback, CPD those kind of broad things those will all be there but the content of each one will be ? depending on what the speciality is.

Lynn: The other thing I want to ask you about is that I gather that it's going to be ruled out as you say as and when it's appropriate but differently in each of the devolved administrations is that correct?

Niall: Yes, I mean it will be different. The exact way in which it would still develop but I think the principle is we will be looking for institutions or areas where they are sort of saying we are ready to go, you know, we have now got systems in place and all the ? enabled to do that and we will look for earlier doctors who will take it forward so that might be GP's in Wales because those ones are pretty well advanced, am not committing them by the way, am not trying to commit anybody to anything but it seems to be that sort of group if they were pretty well advanced and had the systems in place that would be ?

Lynn: So it would not necessarily be England first it could well be the Wales? First with GP's. England might be the first with surgeons, Scotland might be?

Niall: Yeah, and for England it might well not be England, it might be an NSJ or it might be an individual trust that has put staff together, it might be independent doctors for them who are going to be an arrow for lots of lots of independent practitioners so it could vary.

Lynn: Are you going to try and assure them that for the UK wide there is still a consistent approach?

Niall: Yes. We have got to learn from the experiments that are going to go on and there will be experiments going on or pilots rather in each of the parts of the UK and there maybe, I think we are talking about local sort of arrangements so we are not going to impose how long an appraisal lasts or how they actually run their appraisal system. What we are going to do is to set up a framework which says these are the things that we have agreed in terms of generic standards through General Medical Practise or these are the things that have been said that are agreed about the speciality. You have to fulfil that in a sense how you go about it will vary. We would also expect and this is also I think another cause of concern, this isn't a system whereby you as a doctor are told this is the person who is going to appraise you, by the way they are your kind of line manager and you if don't like them very much and they will come along ? and that can't happen. The appraiser should be, if a doctor has a problem with their appraiser, there should be a mechanism by which they can raise that and certainly I would think its good practise for example that they have the same appraiser over five years but not least because if it becomes too cosy as well as you know difficult. And a responsible officer which people are getting concerned about will not usually be the appraiser, they are next level up there, they have seen tonnes of stuff and they are just validating the process as it works, that has gone through.

Lynn: But, I mean obviously they wont ? obviously. It seems to me if there were one area of concern it would be the single handed GP's. Am I right in thinking that?

Niall: You mean concern among them?

Lynn: Well concern about who is actually going to keep on checking on them because they are not working in an environment where other people are around them?

Niall: Again we will have to be careful. I mean there are some absolutely brilliant individuals who work on their own but it is good practise for anybody who is working on their own to be part of something whereby they are able to seek the advice of colleagues and they are able to exchange ideas and get support when required. As far as revalidation is concerned, the obligation on this will have on the single handed practitioner is the same as that of

somebody who is working in a small practise or a team or anything else. They will have to produce the evidence around those things I have talked about. About their CPD's, about details of their practise, the people that they treated this sort of thing, the outcomes where we could do that or the process that have gone through and also they will have to produce evidence from patients and colleagues.

Lynn: Just going back to the issue we were discussing earlier, which is the issue of doctors of other EU countries. How will they fit into this process?

Niall: Well, they will fit in the same way, they are entitled to registration in this country and a licence to practise and they will have to undergo a process of regular appraisal. We need to revalidation. In one sense revalidation there helps us, then not immediately of course when they first arrive. But although over a period of time, it will provide us with some assurance of their competence of fitness to practise which we can't currently provide.

Lynn: I guess the sort of worst case scenarios is that they just can work here for a year and then go back to wherever and you end up with a sort of structure of doctors who aren't and are never going to be part of the revalidation process.

Niall: Yes, I think if they come and work here again they have to be subject to a system of clinical governance so that if they have to have an appraisal of course if they just come up to six months and then they disappear, if they come back then the clock starts ticking again you know. So they cant, you cant sort of go there now and pretend you are not

Lynn: So it will kind of be continuous in effect?

Niall: Yes. I think even if they are especially this thing on the register and ? will be asking why are you coming back on again? If they stay on the register, it will be a bit like being a part time doctor, they would still have to have regular system of appraisal and they would still have to be able to demonstrate that they ?

Lynn: Even if they were not actually practising in this country as long as they were on your register?

Niall: If they want to stay on the register, they will have to demonstrate their competent with fitness to practise.

Lynn: Ok. Fine. Before I move on is there anything else you want to mention around revalidation specifically?

Niall: No. I think we recognised that it is a big challenge. I think we recognise too that there is still a big communication job to do and that we also recognised that we have to be flexible and in listing mode and be willing to

adapt the model to make it as effective as we possibly can and that it is proportionate to the benefits that it will bring.

Lynn: Alright. When is the deadline for actual enforcement going into implementation of this?

Niall: Well, there isn't a deadline for implementation, I think first of all the consultation is from March to 4 June and then there will be the pilots and then we ? in 2011 probably towards the end that we would be starting to roll out from that point

Lynn: You talked about the communication issue as a former journalist what do you think the GMC should be doing to try and improve its image in line of the public. What role do you think?

Niall? In the public?

Lynn: Yeah

Niall: Well I think its interesting. I know that I if you went to the street out here and asked the people what is the GMC? I don't think even those who understand how the country is run and whatever body works would be able to tell you what the letters GMC stood for and there would be lots of confusion between the BMA and the GMC. I certainly found out when I was first appointed because I thought it would be the BMA. So I don't think our ambition should be that everybody on the Clapham, Edinburgh or anywhere else under this really understands anything about the GMC. I do think however, we have a job in ensuring that organisations that represent patients or organisations that help patients and organisations that run health care services absolutely understand what we do and what we think not least so that they can refer correctly to us where there are concerns so I think that is important that people understand ? The other big area where I think we have got a lot of work to do is with the profession the GMC has changed very considerably and you can point to all these changes of professionalisation about fitness to practise works, I think the way in which our standards work is now regarded as world leading and not necessarily celebrated in this country with there are various kinds of things that we absolutely want to get across to the profession but we also want to be listening to members of profession we have to engage more effectively with the profession be it listen more to what the profession is concerned about and ensure that they have us as the regulator and the profession itself are responsive to societal changes because that's when things go wrong when either of us are not in touch with what it is that patients and the public expect and how above all together and it is really together, we have to maintain the trust which absolutely lies on the heart of the doctor patient relationship and maintaining that trust is absolutely critical to our mission. Our mission is to protect the public but in doing that it is about maintaining the trust that people have in the profession.

Lynn: And how are you going to try and ensure that you do that with the profession?

Niall: I think we have got to look at a new ways of reaching out. We have had an experiment last year and we are going to try out some more whereby we have people who understand our processes but will also be out in the field and will be working with medical directors and individuals, doctors explaining what the GMC does, listening on the ground to what people are telling them about, issues that would affect regulation. So I think we have to do a job there and I also think you know we have fantastic new responsibilities from the beginning of April to the entire educational curriculum. So the GMC has a role from the day that you walk into medical school to the day that you retire and I think there are communications around what we do and there are communications with education providers all that is really ? for. That the people understand what our role is and can influence what our role is.

Lynn: ? journalist to help policy ? is it better to be on the outside throwing stones or to be inside literally the ?

Niall: Well, I think it is always better not to regret about your career. I think you move on to new and different things. I enormously enjoyed my time at the BBC and I got ? from it. But I was very anxious about 16 years there although I had a management role within the BBC to start running and getting my hands on organisation that will bring about change. I had a break 6 years ? where I think we made very significant advances and not releasing them relating to social care, safety of the maternity services and around long term care and really pushed some of those issues up the agenda and changed the way the policy works so that was all so rewarding. The challenge here is a different one that is absolutely central to the provision of safe care in this country, absolutely critical in the future of the profession and maintaining it while ? status. And again we do not celebrate enough the fact that the medical profession in this country is a world leader. The system of regulation of this country, not necessarily land within the country, is admired through out the world and we need to celebrate that. We need to improve and develop it and continue to make a response here to what the patients and the public expect of us as the regulator and also the professional staff.