Report of the Committee of Inquiry into the Regulation of the Medical Profession.

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Chairman: Dr A W Merrison FRS

Presented to Parliament by the Secretary of State for Social Services, the Lord President of the Council, the Secretary of State for Scotland, the Secretary of State for Wales, and the Secretary of State for Northern Ireland by Command of Her Majesty April 1975

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MEMBERS OF THE COMMITTEE

*Dr A W Merrison DL FRS	Vice-Chancellor of the University of Bristol
*Dr J R Bennett MD MRCP	Consultant Physician, Hull Royal Infirmary
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Secretary: Mr B Bridges

*Appointed by the Secretary of State for Social Services.
†Appointed by the Secretary of State for Scotland.
**Appointed by the Secretary of State for Wales.

The estimated cost of this Report (including the expenses of the Committee) is £51,750 of which £7,050 represents the estimated cost of printing and publishing.

Rt Hon Barbara Castle MP
Secretary of State for Social Services

Dear Mrs Castle,

On behalf of the Committee of Inquiry into the Regulation of the Medical Profession, I have the honour to submit our report to you and your colleagues the Lord President of the Council and the Secretaries of State for Scotland, Wales and Northern Ireland, to whom I am writing in similar terms.

Sir Keith Joseph, when Secretary of State for the Social Services, asked us to complete our work as quickly as we could since the issues involved are of the greatest importance both for the medical profession and the public. This we have done, consistent with the thoroughness which the complexity of the problem demands.

We should perhaps emphasise, since we were a committee of seven doctors and seven lay members under a lay chairman, that we are wholly unanimous in submitting our report. Indeed, at no time in our discussions did a "lay" view or a "medical" view emerge. The reason is simple. The wise and efficient regulation of the medical profession serves the interests both of practitioners and the public.

It is a particular pleasure to record here the great debt we owe to the imaginative and thorough work of the Committee's secretary, Mr Brian Bridges, and those who helped him in arranging the work of the Committee and preparing this report. Their skill and patience in dealing with the evidence, those who gave it, and us, is beyond praise.

Yours sincerely,
A W Merrison.

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INTRODUCTION

To:

Rt Hon Barbara Castle MP
Secretary of State for Social Services.

Rt Hon Edward Short MP
Lord President of the Council.

Rt Hon William Ross MBE MP
Secretary of State for Scotland.

Rt Hon John Morris QC MP
Secretary of State for Wales.

Rt Hon Merlyn Rees MP
Secretary of State for Northern Ireland.

Appointment and terms of reference

On 23rd November 1972 the Rt Hon Sir Keith Joseph Bt MP, then the Secretary of State for Social Services, announced that he had decided, in conjunction with the Secretaries of State for Scotland, for Wales, and for Northern Ireland, and the Lord President of the Council, to set up an independent Committee of Inquiry with these terms of reference:

> "To consider what changes need to be made in the existing provisions for the regulation of the medical profession; what functions should be assigned to the body charged with the responsibility for its regulation; and how that body should be constituted to enable it to discharge its functions most effectively; and to make recommendations."

The announcement of our appointment was completed in February 1973, we held our first meeting in March of that year, and by June were receiving evidence.

Our appointment followed a long dispute within the medical profession about the manner in which the profession is at present regulated. This had been brought to a head by the introduction by the General Medical Council, as the central regulating body of the profession, of an annual fee for the retention of a doctor's name on the medical register. Previously a single payment at the outset of his career secured the doctor an entry in the register for life. A number of doctors felt that the imposition of an annual retention fee was unjust and yet another example of what they considered the generally bad state of the regulation of the profession. To precipitate a crisis they refused to pay the fee and in turn the General Medical Council threatened to remove them from the register, thus in effect debarring them from practice. At that point the Secretary of State for Social Services intervened with his announcement that this general inquiry into the regulation of the profession should be set in motion, and thus averted what would have been a grave situation.

The evidence we have received has simply confirmed the view that the unease felt by the medical profession about the machinery for its regulation was justified; the freedom which our terms of reference have given us has therefore been as necessary as it has been welcome.

Our manner of working and reporting

In the time we have been at work we have received and considered a great deal of evidence, both written and oral. This evidence has come from the principal bodies within the profession or closely connected with it, from non-medical groups and from individual doctors and members of the public. We made considerable efforts to seek comment and advice from all those with an interest in the regulation of the medical profession: the regulators, the regulated, the providers and the recipients of education, training and employment, and patients, both by means of personal invitation and by canvassing in the press. We have taken oral evidence from representatives of the major professional groups, the Government and the General Medical Council. We gratefully acknowledge all this help. In Appendix A we list those who gave evidence to us, but here we mention particularly the General Medical Council and the British Medical Association. On the General Medical Council we laid a heavy burden by our many enquiries. The Council has always responded clearly and quickly. The British Medical Association went to a great deal of trouble to respond quickly and thoroughly, and this set an important example to others.

Our inquiry into the regulation of the medical profession was the first of its kind for a century. Since then the practice of medicine has been transformed and so has the society in which it is practised. It must never be forgotten that the regulation of the profession is as much a matter of concern for the public as it is for the profession itself: our composition as a committee—seven doctors and seven others under a lay chairman—reflected this.

Our inquiry was necessarily wide-ranging, and we apologise for the length of our report which we fear may make it tedious even to the dedicated reader. It is long for several reasons. The subject is at first blush a complex one and appears even more so after study. Then too, in the evidence submitted to us, and elsewhere, we have found a degree of misapprehension and sometimes pure ignorance about the present system of regulation which made it essential that our report should contain a considerable amount of straightforward description of the present system, so that the changes we propose can be read in a proper context. Then too, we felt that our report, which contains recommendations which are bound to be controversial, should set out at some length the arguments which led us to those recommendations, not only in the hope that in this way we shall carry greater conviction but also to enable those who will oppose our views to marshal their arguments more economically. We are not so foolish as to believe that we have discovered a mine of truth, and we wish to encourage informed debate on our proposals. In order to lighten the burden which we have placed upon the reader, we begin our chapters on the main functions of the General Medical Council with preambles which will show the general path we follow in those chapters. In addition, each chapter is divided into parts and sections, each with a heading which explains itself. Finally, we summarise our principal conclusions and recommendations at the end of each chapter; for convenience these are numbered serially separately from the chapter and paragraph numbering.

CHAPTER 1: MAIN PRINCIPLES AND PROBLEMS OF REGULATING THE MEDICAL PROFESSION

The nature of regulation

1. The essential character of a profession is that the members of it have specialised knowledge and skills which the public will wish to use. The public therefore have an interest in being able to recognise a qualified practitioner and will wish to be provided with a register of the qualified. Any such register, if it is not to be a fraud on the public, must list only those having a certain standard of competence. The body responsible for maintaining the register has therefore two duties to discharge. First it will have to assure itself that those admitted to the register are competent. Secondly it will have to remove those practitioners unfit to practise. The maintenance of a register of the competent is fundamental to the regulation of a profession.

2. This theory was turned into practice in the United Kingdom for the medical profession by the Medical Act 1858, the preamble to which stated that it was "expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners". In 1970 the General Medical Council wrote that "the whole of the Council's functions flow from that original objective . . . . It can be said that the general duty of the Council is to protect the public, in particular by keeping and publishing the Register of duly qualified doctors, by ensuring that the educational standard of entry in the Register (and thus in the profession) is maintained, and by taking disciplinary action against registered doctors if it appears, by reason of their misconduct, that they may be unfit to remain on the Register".

Whom does regulation benefit?

3. The benefit conferred on the public by the maintenance of a register of the competent is obvious enough. The advantage to the profession is no less obvious, since the register will confer public recognition on the competent practitioner, the practitioner whom people will wish to consult and who will thus be able to command a reward for his services. This identification is buttressed by certain provisions of the medical legislation conferring privileges on the registered medical practitioner and protecting his status.

4. An instructive way of looking at regulation is to see it as a contract between public and profession, by which the public go to the profession for medical treatment because the profession has made sure it will provide satisfactory treatment. Such a contract has the characteristic of all freely made contracts—mutual advantage.

How the medical register[1] works

5. The purpose of the medical register is to establish publicly the recognition of the competent medical practitioner. Whether it was ever the case that members of the public used the register in an immediate practical fashion to select a doctor seems doubtful. Even if it has ever been the case in the past

[1]Paragraphs 365–375 deal with the mechanics of the register, and a footnote to paragraph 365 sets out the precise terms (those used in legislation) to describe the register.

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it is not so now. Most members of the public receive medical care through the National Health Service,[1] and expect that the services of qualified practitioners will be provided. This does not mean, as some of those giving evidence to us have appeared to think, that the register is any the less significant. The essence of the register is that it is the exact, the authoritative, the legal list of those practitioners who possess the required competence. As such, the register is used by NHS authorities and others: in other words the public uses the register at one remove.

The basis of the power of the General Medical Council

6. The basis of the power of the General Medical Council[2] is its stewardship of the register. This power is obvious enough in relation to the individual doctor who is prevented from practising because of his professional misconduct. More significant is the power to place a name on the register, because it is this power which is at the root of the GMC's power over educational institutions. The power over institutions arises as follows. Registration is founded on a certain standard of competence. The GMC must therefore specify this standard of competence and ensure that only the competent are placed in the register, and must be able to refuse to accept that an educational body has inculcated the necessary competence. The other way of looking at this power is to consider the result if the GMC simply made entries in the register at the dictation of others. Then any doctor—or pursuing the argument to its absurd conclusion, any layman—could devise a qualification for himself and have it listed in the register. The example is not so ridiculous as it may appear to be: very small groups of doctors have tried to get the GMC to register their membership of an association they have just formed.

7. The powers of the GMC which we have described are of course essential. They assume a crucial importance since the public must be assured that standards of medical care are being properly maintained. If a system of registration were to be set up for Punch and Judy men, for example, the registering body would have the power we described, and for just the same reason. The difference would be that the registering body would not need to be very fussy about the training needed for entry to the register or the grounds for removing practitioners' names from it, since the only result of a bad list—so long as it was not so bad that nobody thought it worth consulting—would be a few disappointed children. The results of a bad medical register are too obvious to need stating.

8. We would not labour this essential power of the GMC as keeper of the Medical Register were it not for the amount of evidence we have received which misses this fundamental point. This is particularly significant in relation to specialist registration where the desirability of a specialist register seems to be generally accepted whereas the means—the control the GMC must necessarily acquire over the providers of specialist medical education—is recoiled from. We return to this in chapter 2.

[1]Abbreviated to NHS in the rest of this report.
[2]Abbreviated to GMC in the rest of this report.

The maintenance of the standards of the medical profession

9. This report is concerned with the exercise of the powers whose origins we have just described. We state here—the arguments emerge in the body of our report—that in this country, at least, the body exercising these powers must be independent. It must be independent of the providers of the country's health service, and it ought not to be the creature of Government.

10. We have suggested that the regulation of the profession can be looked upon as a contract made between the public and the profession. It is important to understand in this context that the GMC is merely the instrument for the proper supervision of this contract and that it derives its authority, and indeed its being, from legislation. The legislature—that is, Parliament—acts in this context for the public, and it is for Parliament to decide the nature of the contract and the way it is to be executed.

11. We take the view that the medical profession should be largely self-regulated. The principal reason for our view is that we have no doubt that the most effective safeguard of the public is the self-respect of the profession itself and that we should do everything to foster this self-respect. The evidence put to us by the profession, through its various professional bodies, was devoted almost entirely to the question of how the profession might best serve the public interest, how it might be ensured that doctors of only the highest competence were put on the register, and how the professionally incompetent might most effectively and justly be removed from the register.

Some general observations

12. We devote the rest of this chapter to sketching the nature of the principal problems of regulating the medical profession, but here we wish to make four preliminary points.

13. In developing our views on the regulation of the medical profession, we come to the conclusion that these powers could be exercised only by a regulatory body (and we retain for it the name "General Medical Council") constituted in a way substantially different from the present GMC. Our proposals for education and the judging of a doctor's fitness to practise must be read with this always in mind. *When, therefore, we refer to the GMC in the rest of this report we mean (unless the context is historical) the GMC which we recommend to take the place of the present one.*

14. We do not attempt, in the report which follows, to solve all the problems of regulating the medical profession. Our task has been primarily to recommend machinery for the solution of problems and in some areas to point the direction of possible solutions which the profession itself must work out. What we have suggested is a framework within which difficulties can be resolved and which, we hope, will satisfy the profession and the community it serves; and be sufficiently efficient and flexible to take account of rapid continuing progress in science and technology, the changing use of medical resources, and the movement in attitude and outlook of the profession and public alike.[1]

[1]We have, for example, deliberately eschewed elaborating our views on medical education beyond the point necessary for the understanding of our proposals for its regulation.

15. We stress that the best machinery in the world does no good unless it is used, and used with diligence and discrimination. The GMC has been criticised to us for failing to use the powers it has—for example to revise the content of the undergraduate curriculum so as to secure more concentration on mental illness and the diseases of old age, or to take firm action against the irresponsible prescription of drugs by doctors. We make no direct comment on these criticisms at this point but we wish to stress the vital importance not only of good machinery but of the will to use it.

16. We have been kept informed of the progress of negotiations on the European Economic Community Medical Directives aiming at the freedom of movement and establishment for doctors who are nationals of, and qualified in, member countries. While we have made no special effort to tailor our recommendations to fit in with the provisions of the directives likely to be promulgated, we believe, on the basis of the information which we have been given, that none of our recommendations will conflict with what is developing in Europe. We say more about Europe in chapter 3.

Medical education and registration

17. The statutory definition of a doctor in this country's medical legislation is based on his education. In our report we devote considerable attention to explaining how medical registration recognises a certain standard of education. We believe that the GMC's task of defining the educational requirement for entry to the register is in general its most important task, and we therefore regard as being particularly significant those of our recommendations which relate to medical education.

18. There are three major differences between what is required of the education of a doctor now and what was required when the GMC was established in the nineteenth century. First, all that a doctor then needed to know could be compressed into an undergraduate course. That is no longer the case and the need for postgraduate training before a doctor can be regarded as fully competent is not disputed. Secondly, in the early days of the GMC the prime function of the GMC was to maintain a minimum standard. Nowadays, having regard to the competence and responsibility of university medical schools and other bodies concerned with medical education, the task of the regulating body must be seen as the promotion of excellence. Thirdly, the education of a doctor, whether consultant or general practitioner, is a complex and lengthy business continuing, as it does, until he ceases to practise: a very large number of bodies with different rôles and responsibilities must play a part in it.

19. Our task in relation to medical education has therefore been twofold: to consider how the changed view of how much education a doctor ought to have received should be reflected in the registration system; and to consider how the responsibility for co-ordinating the whole education of a doctor should be discharged.

Doctors from overseas

20. Entry to the register for home-educated doctors is controlled by controlling educational institutions. The problem in relation to doctors educated overseas is the extent to which the GMC ought to accept the standards of educational institutions overseas. Our changing relationships with the Commonwealth and with the European Economic Community are obviously relevant in this connection.

Fitness to practise

21. A system of registration requires the existence of procedures for taking action where doctors ought no longer to be allowed to treat the public. In chapter 4 we consider the aim, scope and nature of these procedures. The remaining theme of this, our most detailed chapter, is combining the efficient protection of the public with fair and humane treatment of the practitioner.

Other aspects of regulation

22. In chapter 5 we deal with some of the lesser, by which we do not mean unimportant, tasks of the regulating body. We examine the extent to which the GMC should provide ethical leadership of the medical profession. We look at the registration procedures of the GMC. Although the latter subject, on which we have received a considerable amount of evidence, does not have the profound significance for either public or the profession possessed by some of the larger issues we deal with, we nevertheless believe that matters of this kind must be looked after meticulously.

Composition and finance of the regulating body

23. We are in little doubt that if our recommendations are accepted they will result in a regulating body with responsibilities considerably extended compared with those of the present GMC. We believe, therefore, that the composition of the regulating body should be changed very considerably and we devote one of our chapters to this topic, and to the financing of the GMC.

The rôle of the GMC

24. Although it is very little in the public eye, and then only on trivial occasions, the importance to the public of the part played by the GMC cannot be over-estimated. It is largely for this reason that we have ranged so widely in our inquiry and why our recommendations cover so wide a field. We have little doubt that our recommendations will be scrutinised closely and indeed we should feel uneasy should it not be so. The health of the nation will be founded on the cornerstone of the wise and responsible practice of medicine, and that practice is in its turn founded on the wise and responsible regulation of the profession.

Our principal conclusions in Chapter 1

(1) Medical registration provides a means of recognising the competent practitioner (paragraphs 1 and 2).

(2) It is advantageous to the public to be able to recognise, and to a member of the medical profession to be regarded as, a competent medical practitioner (paragraphs 3 and 4).

(3) The medical register is used by the public at second hand (paragraph 5).

(4) A medical register necessarily involves a registering body with considerable powers, particularly over the providers of medical education (paragraphs 6–8).

(5) The medical profession should be largely self-regulated and should be regulated by an independent body (paragraphs 9–11).

CHAPTER 2: EDUCATION AND REGISTRATION

PREAMBLE

This chapter is concerned not with medical education as such but with its regulation, which we take to embrace the supervision of the education of individual doctors, the overall control of standards of medical education, and in some measure the provision of resources for such education. The regulation of medical education centres on the statutory registration system; that is, the list of those who have acquired a defined amount of knowledge and skill. The power of the registering body—much underestimated and often misunderstood—rests in its power to determine the standard of competence which it will require of those wishing to be registered. We believe that the education of the medical profession should reflect the medical science and practice of the latter half of the twentieth century, and that the registration system should now be re-fashioned to recognise that postgraduate education is essential to the making of a doctor. Such a recognition will enable the new GMC to co-ordinate the planning of the specialist stage with the planning of the other stages of medical education. We regard it as vital that medical education should be treated in all respects as a continuum. We think that the present regulation of undergraduate education is broadly satisfactory; that the next phase, that of making a clinician of the graduate, requires radical re-organisation; and that specialist education should be regulated on the basis of recent developments in that field. We think that the Regional Postgraduate Committees and Central Postgraduate Councils have an important role to play in matching and co-ordinating educational needs with the demands of patient care.

PART A: EDUCATION AND REGISTRATION

The relationship between education and registration

25. To follow our recommendations on medical education, it is necessary to understand the relationship between education and registration, and to understand the educational function of the registering body.

26. The purpose of medical registration is to enable the public to recognise the competent practitioner. It follows that an indispensable feature of any system of registration is that it shall mark the attainment of a certain educational standard. It might, of course, mark a series of standards—there is no reason why a registration system should recognise only one standard. Medical registration may work simply by providing a public list of the names of those who have reached the appropriate standard—this is usually described as an "indicative" register. Such a registration system works because patients, when provided with the means of making the choice, will naturally resort to the qualified in preference to the unqualified. Nowadays, orthodox medical practice is in effect reserved to those on the medical register[1] so that registration does not work so much through its indicative character as by the exclusion of the unqualified. This reservation of medical practice to the qualified is not an essential feature of the medical registration system whereas the recognition of qualification is.

[1]See paragraph 33.

27. Whether the registration system works by its indicative character alone, or is reinforced by restricting practice to the registered, registration will provide the practitioner with a certificate of competence which will enable him to earn his living. The advantage registration gives the practitioner in earning his living is the prime attraction of securing registration, but it may be noted that registration also confers certain legal privileges with which we are not much concerned in this chapter. The advantages conferred by registration are such as to ensure that practitioners conform to the educational and other requirements of the registering body; or put another way, the registering body is able to compel compliance with its requirements because registration is so necessary to the practitioner.

28. A change in the educational standards for doctors necessarily has consequences for medical registration, for otherwise the registration system gets out of step with educational standards. There are three ways in which the educational standards of doctors can be changed, while keeping the registration system in step. First the range or quality of the education needed for an established registration category can be changed. It might, for example, be thought desirable that in the undergraduate stage, less instructional emphasis should be laid on obstetrics and more on geriatrics. This sort of change is brought about by the GMC at present, notably by the periodical issue of recommendations to medical schools.[1] It is the ordinary sort of change needed to take account of developing views about the relative importance of various areas of medical knowledge. Secondly, the level of education needed for an established registration category can be increased or decreased. This is roughly what happened as a result of the Medical Act 1950. Before that Act came into force in 1953, completion of the undergraduate course conferred the right to full registration. Since 1953, full registration has been granted only to those who, in addition to having completed the undergraduate course, have worked in a hospital for a year. Both these methods of changing educational standards use the full compulsory force of the present medical registration system: those who do not comply do not receive registration, and without that registration they are unable to earn their livelihood. A third way of changing educational standards is to introduce new registration categories linked to new educational requirements. This method, depending on the provisions of the new registration categories, might not be so completely compulsory as the previous two, but the inherent recognitionary character of the registration system—what registration level has he got?—must ensure its very considerable impact.

Education, registration, and the planning rôle of the regulating body

29. Registration is meaningless unless it recognises a known and accepted standard of education. Any registration system consequently involves the registration body in the planning, setting and control of educational standards. If medical registration were granted upon satisfactory completion of a national test, the content of the test would have to be planned and approved nationally. As it is, the testing of individuals to see whether they are eligible for medical registration is, in the United Kingdom, carried out for the most part by the universities. In these circumstances it is the duty of the GMC, as the registration

[1]See paragraph 36.

body, to ensure equivalent standards. *Any* system which is dealing with the registration of qualification granted by separate bodies must insist—the process is quite ineluctable—on those qualifications being of roughly equivalent standard. It is instructive to consider what would happen if there were no such insistence: that is, if the GMC acted solely in a clerical capacity and granted registration to those obtaining any primary medical qualification awarded by medical schools even though, for example, one primary qualification was granted after a year whereas the next took five years to obtain. Quite evidently such a system would not long survive the rush to the one-year school and the bitterness of the five-year graduates—not to speak of indifference among the public to registration, if it represented such a variable standard. The point is that a registration system of necessity demands a regulating body to indicate and bring about equivalent standards. Equivalent standards do not require uniformity, and this has been neatly expressed by the GMC: "The Council thinks it is now widely accepted that in medical education there is no single pathway to success. Identity resides not in the paths but in the goal".[1]

PART B: THE EXISTING SYSTEM OF MEDICAL REGISTRATION AND CONTROL OF EDUCATION

The statutory system of registration and its relation to the educational system

30. This section describes the present statutory registration system, setting out its educational requirements and explaining the means by which the GMC enforces those educational requirements. The present system incorporates two grades of registration, recognising, respectively, the completion of undergraduate training and of a year's practical experience in hospital. To control the area of medical education for which it is responsible the GMC has a range of statutory powers which we believe to be less immediately significant to the work of control than the informal methods which the GMC also uses.

(*a*) *The range of the GMC's control over medical education*

31. The Medical Act 1886 required all doctors, in order to become eligible for registration, to have passed qualifying examinations and the "standard of proficiency required from candidates at . . . qualifying examination(s) shall be such as sufficiently to guarantee the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery; and it shall be the duty of the Council to secure the maintenance of such standard of proficiency as aforesaid". Essentially the aim was to ensure that the registered medical practitioner has a sufficient knowledge of medical science, and was clinically competent to give effective care to his patients. The Medical Act 1950 made it compulsory for every doctor, after passing his undergraduate qualifying examination, to spend a period as a resident house officer in an approved hospital before he became fully registered. The Act came into force in January 1953. These provisions were re-enacted in the Medical Act 1956.[2] In summary, then, the scope of the GMC's control of medical education extends only to the undergraduate stage and the year immediately following.

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[1]Recommendations as to Basic Medical Education; 1967

[2]The quoted provision of the Medical Act 1886 is now provided by Sections 10(1) and (3) of the Medical Act 1956. The provisions governing the year after graduation are Sections 15-17 of the Medical Act 1956.

(*b*) *The grades of registration*

32. Apart from temporary registration, which is applicable only to doctors trained overseas, there are two grades of registration, provisional and full. To be eligible for *provisional registration* a doctor must first have passed a qualifying examination in medicine, surgery and midwifery held by one of the bodies or a combination of bodies described in Section 11 of the Medical Act 1956; and, secondly, he must hold one or more of the registrable primary qualifications, for example the degree of MB BS or diplomas of MRCS LRCP, listed in the same act. Provisional registration entitles a doctor to work only as a resident house officer in a hospital approved for pre-registration house officer service: the power of approval is vested in the universities.

33. To obtain *full registration* a doctor must have fulfilled the two conditions of provisional registration described above and obtain, from the body which granted his qualification, a certificate that he has completed 12 months' satisfactory pre-registration house officer service. Full registration is of great significance to a doctor. The necessity for registration is taken for granted by the medical profession. It is in certain circumstances considered to be serious professional misconduct on the part of a doctor to work with an unregistered practitioner; and certainly there would be general reluctance on the part of other doctors, nurses and auxiliary staff to work with an unregistered practitioner. This general acceptance of the need for registration is reinforced by certain statutory provisions. The following provisions ensure that only registered practitioners may provide medical services through the NHS. Section 28 of the Medical Act 1956 ensures[1] that only registered doctors shall hold a medical appointment in any hospital, including NHS hospitals.[2] Section 33 of the National Health Service Act 1946, in the context of other legislation, ensures that only fully registered doctors may provide NHS general practitioner services. The main reason why registration is necessary for the *private* practitioner is that, as we have explained, the necessity for it is taken for granted on all sides. Apart from this, Section 29 of the Medical Act 1956 provides that no medical certificate required under any enactment shall be valid unless given by a registered practitioner, and Section 27 of the same Act prohibits the recovery through the Courts of fees for medical treatment, unless the person seeking recovery is registered. Under the Medicines Act certain drugs may be prescribed only by registered practitioners.

(*c*) *GMC powers of control over undergraduate education*

34. The first aspect of the GMC's control over undergraduate medical education is its fundamental power as the registration body to withhold recognition of the educational qualification of an institution: that is, to refuse to place on the medical register those holding the institution's qualification. This power involves complicated statutory provisions reflecting the diversity of licensing bodies and the historical arrangements made to recognise the qualifications they grant; and exercise of the power depends to a more or less direct extent on the concurrence of the Privy Council. The last time that the power was actually resorted to—that is, the last time the GMC took action to prevent

[1]Save in certain rare circumstances.

[2]The same provision ensures that only registered doctors shall hold a medical appointment in the armed forces or in a prison or other public institution.

a primary medical qualification from being registrable—was in 1971. This was an exceptional case and the power has been used rarely. It is, however, the power to refuse to accept a qualification upon which the whole structure of educational control by the GMC as the registration body ultimately rests.

35. The second aspect of the GMC's control of undergraduate education is its direct supervisory powers. These powers are conferred by the medical legislation and there are three elements. First, any member or members of the GMC or any person or persons deputed for this purpose by the GMC may attend and be present at examinations for registrable qualifications.[1] Secondly, and more generally, the GMC is empowered to appoint inspectors to attend qualifying examinations.[2] The inspectors report to the GMC their opinion as to the sufficiency of examinations which they attend, and on any other matters in relation to such examinations on which the GMC requires them to report. Thirdly, the GMC is empowered to appoint visitors of Medical Schools.[3] The legislation provides that such visitors should not be members of the GMC, that visitation of schools should be subject to any directions given by the Privy Council; and that it should be the duty of the visitors to report to the GMC on the sufficiency of the instruction given, and on any other matters relating to such instructions specified by the GMC either generally or in any particular case. These three direct supervisory powers have been used sparingly in recent years and it is interesting to note the GMC's explanation:

> "One reason why no general visitation and inspection of Medical Schools and examination in the United Kingdom has been held for 15 years was that the Council felt some doubt whether the formal kind of visitation and inspection which the Act contemplates would, if carried out generally, be a useful exercise in contemporary conditions. It appears unlikely that Medical Schools of universities in the United Kingdom would be found insufficient in respect of their curricula and examination, unless the Council had previously become aware of the development of a potentially unsatisfactory situation".

36. The third aspect of the GMC's powers is the general advisory and persuasive influence it exercises as the regulating body. The GMC has told us that "the main influence exerted by the Council over undergraduate medical education has been through the periodical . . . publication . . . of Recommendations as to Basic Medical Education. These Recommendations have indicated the range of subjects which in the opinion of the Council should be covered in the undergraduate curriculum, the overall length of the curriculum, and the range and scope of the examinations." The most recent Recommendations were issued in 1967. The GMC has also convened conferences of medical schools and other bodies interested in undergraduate education with the object of identifying problems, suggesting solutions and promoting discussion of future developments. There seems little doubt that the chief influence of the

[1]First introduced by Section 18 of the Medical Act 1858; and now provided by Section 10(4) of the Medical Act 1956.
[2]First introduced by Section 3 of the Medical Act 1886; and now provided by Section 10(3) and (5) of the Medical Act 1956.
[3]First introduced by Section 22 of the Medical Act 1950; and now provided by Section 9 of the Medical Act 1956.

GMC on undergraduate medical education is to be found in this work of discussion, advice, and encouragement rather than in the exercise of its formal powers.

(d) GMC powers of control over the pre-registration year

37. The only statutory powers conferred on the GMC in relation to the pre-registration year were to make regulations prescribing the total length of the period of house officer service (this period was fixed at 12 months) and the periods within the total which were to be spent in medicine and surgery, or which might be spent in obstetrics or in an approved health centre. The GMC did, however, include material on the pre-registration year in its last set of recommendations and has convened conferences dealing with the year.

Specialist medical education

38. The state of specialist medical education now may be likened to the state of undergraduate medical education before control was instituted in the nineteenth century. Many bodies are providing specialist education but there are no means by which the completion of this stage of education may be publicly recognised, a reasonable equivalence of standards of specialist education brought about, or the efforts of the specialist educators co-ordinated with what has gone before.

39. Specialist education is supervised in part by the Royal Colleges and the universities. Higher qualifications, diplomas, and membership or fellowships of Colleges and Faculties were until recently the only means of recognising specialist achievement. The GMC will list[1] some of these marks of success in the medical register but by no means all. Apart from this, the GMC has no standing in specialist education and makes no attempt to bring about common standards or to indicate the significance of any specialist qualification.

40. Following the report of the Royal Commission on Medical Education,[2] Joint Committees on Higher Training have emerged. These Joint Committees exist now for many specialties and provide accreditation in the relevant specialty. We return to the Joint Higher Training Committees later,[3] but here we wish to stress that although they are important in relation to the education of individuals—we have found it helpful to think of accreditation as being to specialist education what finals are to undergraduate education—they do not provide any control of the overall standards of specialist education in the way in which the GMC controls the overall standards of undergraduate education.

41. The Royal Commission on Medical Education proposed a structural control of specialist education, but the Commission's discussion of the subject was essentially subsidiary to discussion of the aims and nature of medical education, and in any event the proposals the Commission made for structural

[1]Providing the holder troubles to register them.
[2]Cmnd. 3569; HMSO 1968.
[3]Paragraph 128.

control were never implemented. The Commission's concept of general professional training has, however, taken a place in postgraduate education. The central idea of general professional training—a sequence of appointments which might be relevant to several specialties—could be considered as a contribution to the establishment of common standards. No overall central control of general professional training was, however, suggested or implemented, so that the direction of general professional training has never been controlled by the GMC or any other body in the way that undergraduate education is.

42. To a certain extent, particularly in Scotland, the Postgraduate Councils have undertaken a role in relation to the standards of specialist medical education, but for various reasons the Councils have not been able to fulfil the role for specialist education which the GMC fulfils in the undergraduate field.

43. It is clear that so far as any overall control of the standards of specialist education exists, it is by the NHS, through its appointments procedure for hospital specialists.

The NHS and its "specialist registration" system

44. We have pointed out that all that the statutory registration system requires of a doctor by way of education is that he shall have a primary qualification and have completed a year's practical experience. How is it that any doctor can be persuaded to undertake more education than that required to obtain registration? Partial inducements are the intellectual interest of doctors in their subject and their desire to be good doctors. The principal inducement is the fact that professional advancement depends on receiving more education than the minimum required for registration. And this is because the NHS runs—in relation to hospital doctors—what may be regarded as a specialist registration system.

45. The two main characteristics of a registration system—that it recognises a certain educational standard, important to earning a livelihood, and that control is exercised over the educational standards demanded for registration—are both characteristics exhibited by the conferment of consultant status by the NHS. Every consultant has received extensive specialist training. Appointment to the consultant grade involves a procedure laid down in the National Health Service (Appointment of Consultants) Regulations 1974 which seeks to ensure—particularly by the inclusion of members of the specialist colleges and other bodies in the committees—that every appointee has received an adequate specialist education. These NHS arrangements can therefore be regarded as a registration system,[1] albeit an informal and unwritten system.

[1]It may be noted also that NHS consultant status exhibits another characteristic of a registration system in that it defines what the registered person may do. Consultants are distinct from other hospital doctors in carrying independent clinical responsibility for each of their patients in the hospital.

PART C: WHAT IS TO BE DONE?

A summary of our views

46. The prime weakness of the present system of control of medical education is that control through the statutory registration system—largely unchanged since 1886—covers what are now little more than the academic preliminaries to the assumption of full responsibility.

47. There are three stages in the making of a doctor. The first covers the period when he begins to learn the science and skills and to adopt the attitudes which will be the foundation of his practice of medicine; it ends formally at graduation. The second is when he will, as a graduate, begin to learn how to treat patients and acquire the general experience of medical practice which will be necessary to him whatever specialty he follows. This at present consists partly of the pre-registration year, and partly of the period referred to as general professional training. The third stage is the specialist training which will equip the doctor to practise his chosen specialty independently.

48. We share the view which has now become widely accepted that every doctor ought to have received specialist education and we believe that this requirement should be reflected in the statutory registration system.

49. It is our view that to ensure the proper organisation—and thus impact on doctors—of each of the stages to which we have referred they must all three be defined in the statutory registration system. The *first*, undergraduate, stage is already defined in the present statutory system. We do not suggest many changes in relation to this stage. Part of the *second* stage is defined in the present statutory system but the rest is not subject to control which will ensure that all doctors acquire the experience of medical practice which we believe necessary to the making of a doctor. Doctors entering general practice are not placed under any formal pressure to do more than complete the pre-registration year. For hospital doctors the period after completion of the pre-registration year has become more of an introduction to the specialist stage of education than a period of general experience to round off, in combination with the pre-registration year, the undergraduate period. We recommend a new approach to this stage of medical education. The *third*, specialist, stage was not structured at all until the emergence a few years ago of the Joint Higher Training Committees. The schemes of accreditation they have developed have no legal standing, nor is accreditation obligatory for practice in a specialist capacity. We recommend the extension of a full system of control to this stage of medical education through the introduction of statutory specialist registration.

50. We do not believe that the combination of the present statutory system and the NHS "specialist registration" system we have described is an effective substitute for the three stage definition and control of medical education through a statutory registration system which we have sketched in the previous paragraph.

51. The changes we recommend in the statutory registration system, and in particular its extension to cover specialist education, will give the new GMC a regulating function over all stages of medical education. We welcome this because only by having one body overseeing all medical education will it be possible to achieve what we believe has become essential: the *co-ordination of all stages of medical education.* This seems to us the only way of making sure of the satisfactory supervision of each part.

The need for every doctor to have received specialist education

52. The main requirement of the present registration system is that the registered person should have completed an undergraduate medical course which gives him the knowledge and skill requisite for the efficient practice of medicine, surgery, and midwifery. The rapid expansion in medical knowledge and skills has meant that this aim has been, for a long time, unrealistic. The inevitable result of the expansion of medical knowledge has been that every independently practising doctor needs to have specialised in some aspect of medicine, and we include general practice as one form of specialisation. These points were the staple of the report of the Royal Commission on Medical Education: "We start from the premise", the Commission reported, "that every doctor who wishes to exercise a substantial measure of independent clinical judgment will be required to have a substantial postgraduate professional training . . ." This premise appears to be so much absorbed into present-day medical thought that it was implicit in all the major evidence we have received on medical education. Against this background we conclude that the recognition that every doctor requires specialist education should now be embodied in the registration system, and that public means should be provided to recognise the doctor who has received suitable specialist education.

The advantages of the NHS "specialist registration" system considered and found wanting

53. The case *for* the NHS system is that it is flexible: it is designed to ensure the most accurate possible matching of the qualities of the aspirant with the demands of the vacancy in question. Local needs and local opinion can properly be claimed to be of high importance in the selection of someone who is to occupy what may be a crucial place in the community: while the guidance of professional advisers from the Universities and the specialty concerned should provide all necessary assurance against a lowering of standards. In support of these contentions, it can be claimed that the present system has in fact produced a high general quality of service; testimony to this effect comes from a wide variety of sources, including one that has featured massively in our own evidence—namely the wish of large numbers of overseas graduates to participate in the process.

54. We accept the truth of both of these assertions, but find that neither of them has an exclusive claim to virtue. Flexibility of the same nature resides in any system where local opinion is allowed its due weight in an appointments procedure. The matching of candidate to post will be in no way interfered with by the existence of a specialist register: indeed, it could be argued, given the objectivity and independence that a register will provide, that local opinion could properly be allowed a more dominant role than heretofore. The argument

about quality is even less capable of standing up to close examination. High quality in the present system is dependent upon genuine competition and therefore upon a high wastage rate. The extent of the wastage is largely hidden by the fiction that "training" is being continued for those candidates not appointed to a particular post, irrespective, however, of their competence or of the length of apprenticeship they have already undergone. Clearly some lack of congruence has to be accepted between the time of finishing training and the time of consultant appointment. But it is idle to pretend that the service as a whole is well served by there being a long waiting list for consultant status in some specialties and none at all in others; or that the interplay of supply and demand, locally and nationally, is a satisfactory means of making important and predominantly educational decisions, upon the sum of which the overall quality of the service largely depends. We find, therefore, that the claimed advantages are not exclusive to the present system, and that they are in any case advantageous only in individual instances.

The disadvantages of the NHS "specialist registration" system

55. In addition to the supposed advantages turning out in fact to be less substantial than is claimed, we find that the practical weaknesses of the NHS system are extreme. The system extends only to hospital specialties; there is no comparable NHS mechanism to consider the specialist attainment of the general practitioner. The system naturally does not extend to private practice. So far as the nature of the system is concerned, it is plain that a series of committees up and down the country appointed to deal with specific vacancies cannot be a good means of securing consistent standards even within one specialty, let alone among them all. That must be so despite the presence on each committee of external representatives from the Universities and from the specialty in which an appointment is to be made.

56. We have already made it plain that we believe it to be wrong that the providers of a service should also set the standards of medical education. We believe, in particular, that the temptation to appoint a bad specialist simply because a bad one may seem better than none at all should not be permitted to distort standards of medical education. This may seem at first sight to be an excessively doctrinaire or even impractical approach. It is understandable that the local demand to fill a vacancy—usually in a "shortage" specialty with a heavy NHS commitment in an unpopular area—may be so clamant that the judgment of the national panel advisers is over-ridden. But we have no doubt that the consequences of this in the long run will be bad because an "unqualified" doctor has been given the only imprimatur that currently exists, and he wears it for life. We believe the separation of powers of the providers of service and the setters of standards to be fundamental to the provision of medical care in this country.

57. The third weakness of the present system is its prevention of the co-ordination of the planning of all stages of medical education. We have pointed out already that the need for this co-ordination is one of our most important recommendations, and the next section sets out why we regard it as such. Here we point out the impossibility of co-ordination under the present hybrid system. Suppose, for example, it were considered desirable to

drop a subject from the undergraduate course on the grounds that the particular specialists needing that subject would be instructed in it as part of their postgraduate training. While the GMC has the power to secure the first part of such a change, the second part would at present involve persuading numerous independent bodies of the desirability of changing their practice. Even then no assurance that the specialists concerned had in fact received the particular instruction would exist, because the procedure for appointing NHS consultants would not bear sufficient authority to enforce such a condition.

The co-ordination of the planning of all stages of medical education

58. It seems plain that there ought to be efficient co-ordination in the design of successive stages of medical education. For example, a very high level of training in some necessary background science in the undergraduate stage would reduce the amount required later on; similarly, it would be dangerous to the public if a suitable standard of proficiency in clinical skill were not required before graduation, unless further postgraduate experience and training to develop these skills were mandatory for all those who were going to care for patients.

59. Co-ordination of the stages of medical education clearly does not exist at present. A particular failure of the present system is that, because satisfactory completion of the undergraduate course and a year's practical experience allows independent practice, the emphasis of the undergraduate course tends to be on training the "safe" doctor. There is no satisfactory means for recognising any higher level of education. The consequence of this is that undergraduate teachers may concentrate on cramming in as much as possible of the fast-expanding body of factual medical knowledge to the detriment of ensuring a sound grasp of medical science and method. While this cramming process is understandable, it is not sensible given the extent of the division of function among doctors in this country, for this, in turn, means that doctors will not need to be expert in all aspects of medical care. In the postgraduate field there is, similarly, a well developed tendency to push the academic requirements of specialty training to a point where general clinical training suffers. In short, in the absence of overall supervision, those concerned with each part may waste effort counteracting the real or imagined deficiencies of other parts.

60. All these matters are well recognised. Indeed, the evidence we received for the view that all medical education should be under the control of one body can be described as a chorus. The GMC told us:

> "Any arrangements made for the regulation of the professional education and training of doctors should have regard to the essential unity of medical education and should not erect artificial barriers by providing separate and possibly conflicting machinery for supervision of the standards to be required at the different stages of training".

The Government told us that they broadly supported the GMC's view. The British Medical Association told us:

"Medical education is a continuous process. Broadly the Association is of the opinion that the elected and accountable regulatory body should have a co-ordinating and in the last resort a controlling rôle in medical education at every level *provided* that the new body is so composed as to command the confidence of the medical profession".

The Committee of Vice-Chancellors told us:

"All stages of medical education should be seen as related and this should influence any new arrangement for the regulation of professional education and training".

The Junior Hospital Doctors' Association told us that all medical education "must be seen as a continuum" and the Medical Practitioners' Union advocated a body having "wide powers of control over medical education in all its aspects".

61. The proviso to the British Medical Association evidence quoted above indicates what, in the last few years, has been the largest impediment to the making of changes so that all medical education could be co-ordinated. This is that it is thought, especially since such overall co-ordination involves a specialist registration system, that too much power would be put into the hands of the GMC. In considering this aspect it is important to consider *all* our recommendations—including those on the structure of the GMC.

What is to be done

62. Briefly, then, *we propose that there should be a three-tier system of education for every doctor of the future—undergraduate training, graduate clinical training, and specialist training—and that these should be defined in the system of registration and co-ordinated and controlled by the regulating body.* The rest of this chapter is devoted to the working out of this system and defining the responsibilities of the various providers of medical education who will be involved.

PART D: GENERAL ASPECTS OF THE CONTROL OF MEDICAL EDUCATION

Defining the aspects of controlling medical education

63. The control of medical education may be regarded as having three elements. First, there is the *control of individuals* to ensure that they have reached the set standards: that is, the process of assessment, generally by examination of various kinds. Secondly, there is the *control of these standards:* that is, pointing the direction of medical education, setting standards for the bodies actually providing education, enforcing those standards and making sure that, where appropriate, standards are co-ordinated. Thirdly, there is the *control of resources* for medical education.

The control of individuals

64. On the subject of the control of individuals to ensure that they have reached certain standards, we wish to make only one point: that is in praise of diversity. Given that the aim of the system of regulation is to ensure that

every doctor reaches certain standards, it could be argued that the most logical and straightforward system would be for the regulating body to organise central examinations which everyone who wished to be a doctor would be required to pass. To adopt this approach would inevitably impose restrictions on the freedom of the providers of education to plan curricula. The objection to this is that diversity and experiment, and probably vigour along with them, are lost. We believe that the diversity which follows from not having a central system of assessing the standards of individuals is desirable, and we have no reason to believe that the current delegation of individual control to a great variety of educational bodies is anything other than satisfactory. It follows that control of the standards of individuals must rest with the educating bodies. The only rôle the GMC will have in this control will be a general concern with methods of assessment. Our view of the desirability of diversity extends to every stage of medical education.

65. It may be helpful to explain how we see the general relationship between the GMC and the providers of medical education. We have expressed our belief that a diversity of approach is a great strength of education. Nevertheless, while there must always be large areas where different approaches will lead to a broader and better understanding, there must be a consensus on the general direction of medical education, and it will be the GMC's function to give formal expression to this consensus. We believe that the proposals we make in chapter 6 on the structure of the GMC will avoid, on the one hand, this consensus becoming fossilised, and, on the other, experiment for experiment's sake becoming the order of the day. It is however certain that unless the providers of medical education have an adequate voice in the GMC, and unless the *whole* GMC concerns itself with the problems of education, then one or other, or possibly both, of the dangers we have described will occur.

The control of standards

66. In this section we make a general point about the legislative nature of the GMC's control of the standards of medical education. The point is closely linked to the manner of defining the point to be reached at the end of each stage of education. At present there is a statutory definition, in section 10(1) of the Medical Act 1956, of the aim of undergraduate education:

> "The standard of proficiency required from candidates at a qualifying examination shall be such as sufficiently to guarantee the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery".

The GMC, in evidence to us, made the following comment:

> "[This provision] no longer accords with the facts of contemporary medical practice, and with the passage of time [has] become an obstacle to the re-formulation of the undergraduate medical curriculum in the light of contemporary needs. Nowadays it is unrealistic to suppose that any medical student, at the termination of the undergraduate curriculum, can possess the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery. It is only after a considerable period of postgraduate training and experience that doctors are regarded as competent to practise without supervision surgery, midwifery or one of the other branches of medicine . . .".

It will already be clear that we agree with this view, and consider that the present definition on the one hand leads to the crammed undergraduate course and on the other fails to recognise the need for every doctor to have received specialist education. There is, however, a difficulty. If, to have their qualifications recognised, the licensing bodies have to reach a certain standard that standard must have some sort of legal definition. At present section 10(1) provides the definition.

67. One solution would be to recast section 10(1) in different but still specific terms, but that might inhibit flexibility and change. We therefore prefer an approach which does not involve the stifling effect of a specific statutory definition. We recommend that the GMC should be charged with a general statutory duty to promote high standards of medical education. The legislation should, within that duty, provide that the standards to be reached at any stage of registration should be determined by the GMC, and that these standards and their relationship to registration levels should be periodically reviewed. On the face of it, this may appear to be a very large increase in the power of the GMC, since, instead of licensing bodies having to conform to a statutory standard, they would have to conform to a standard *at the discretion of the GMC*. In fact the change is apparent not real, since what the "knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery" should be, must already be a matter for the judgment of the GMC. The modification we suggest has the advantage of setting medical education free of a restrictive legislative concept, and thus of ensuring that the mechanism of statutory control remains in tune with contemporary thought.

Advantages of the GMC's being charged with a general duty to promote high educational standards

(*a*) The technical difficulty of the reference in the present medical legislation to "examination" solved.

68. The GMC has pointed out to us that there are objections to the legislative provisions governing qualifying examinations:

"(*a*) The definition of a qualifying examination in section 11(1) of the 1956 Act as 'an examination in medicine, surgery and midwifery' suggests that each of these three subjects should be given a special place in the qualifying examination. Although surgery and midwifery are still introduced during the undergraduate curriculum, these branches of medicine in its widest sense are now regarded as mainly suitable for postgraduate study and training. The section also prevents an Examining Body from granting exemption from examination in any of these subjects.

(*b*) The concept of 'an examination', while not incompatible with a system of progressive or continuous assessment, does nevertheless not readily accord with arrangements under which the relevant examination may be divided into parts, to be taken at different times, or with the absence of a comprehensive qualifying examination coming at the end of the curriculum. Many Medical Schools have adopted arrangements under which the process of examination or assessment is carried out

in stages throughout the curriculum, and the Council suggests that in any comprehensive revision of the Medical Acts care should be taken to avoid the imposition of requirements which are not consistent with such arrangements".

The recommendation we make for the technical structure of the legislation will solve these problems.

(*b*) Doubts about the powers of the GMC in relation to research work in medical education resolved; recommendations on research.

69. The GMC, as the body responsible for setting and maintaining standards, will necessarily have to have regard to the methods of education as well as its content. The Royal Commission on Medical Education recommended that the GMC should be involved in educational research and we support this proposal. We think that the GMC might itself undertake studies or commission research by constituent or other bodies. It might, for example, do or commission work on methods of assessment. We emphasize the desirability of canvassing students for their evaluation of the education they are undergoing. The legislative imposition of a general duty to promote high standards of medical education should dispel the doubt which we understand exists at present in relation to the GMC's powers in this field.

(*c*) The co-ordination of medical education.

70. The charging of the GMC with a general duty to promote high educational standards complements our recommendation that the GMC ought to co-ordinate the planning of all stages of medical education. If, as now, what is required at any stage of education is statutorily prescribed, flexibility is inhibited. We believe that medical educators will be interested in the potential of the regulatory system we propose for greatly increased flexibility. In particular they will have an opportunity to reconsider the content and length of each of the three stages of education. We return to this theme later.[1] But this is not the only possibility: particular educational institutions might also be able to be more flexible in their curricula. For example, if a particular medical school desired to miss out all but the most basic instruction on, say, midwifery, the curriculum might be approved by the GMC on condition that graduates of that university accepted a requirement to devote a greater proportion of their immediate postgraduate education to midwifery than students of other universities.

The provision of resources for medical education

71. Although the provision of resources for medical education is not directly within our terms of reference, we have been obliged to consider some aspects of the matter in order to examine the relationship between standards and resources in medical education, and more particularly to define the limits of the GMC's work in setting standards.

72. We set out our specific views on the successive stages of medical education in the later parts of this chapter. Here we make two general points. The first is a reiteration of our view that the task of controlling standards of

[1] In paragraphs 117–119 and 141.

medical education should be separated from the task of controlling the resources for medical education. We believe that the job of setting standards gets off to a bad start if the horizon of those who set standards is limited by the immediate pressure of resource constraints. We do not press the argument too far: the absurdity of doing so is evident.

73. On the other hand, we do not believe that those who set standards should have such dominant influence that what is educationally desirable is automatically given priority over non-educational resource claims. We have been told that educators should have a firm hand over the providers of medical services; for example, that the University Postgraduate Deans should have some sort of power to insist on NHS Regional Health Authorities providing suitable training posts. It is evident that NHS authorities could not possibly be placed in such submission to the universities since this could, in the extreme situation, lead to an unacceptable diversion of resources from patient care to education. To say this is not to derogate from our conviction that strong pressure on educational grounds should come from an independent body responsible to the public for maintaining professional standards.

74. Although problems involving the interaction of standards and resources arise in the undergraduate field,[1] those of the postgraduate field are particularly awkward because most postgraduate education takes place in a clinical setting; that is, in circumstances where the prime aim must ever be the immediate care of patients. We believe that the machinery for resolving the problems of the interaction of standards and resources needs to be local, influential, and informal. It needs to be local to deal with the identification of posts within hospitals and general practice suitable for particular training needs. It needs to be influential so that where a general problem is identified it will be properly dealt with, in particular by the NHS. It needs to be informal because it deals with such imprecise matters as the content and nature of the work of a particular training post—and it is, we believe, impractical to think that such matters can be sorted out other than by discussion founded on mutual goodwill.

75. Local, influential, and informal are three adjectives which aptly apply to the Regional Postgraduate Committees. We regard the Committees and the Postgraduate Councils which advise them as vital pieces of machinery. The only general suggestions we have in relation to this machinery is that we think that the constitutions of the Regional Committees which at present vary considerably should be made more uniform; and that we sense that the size of England and Wales makes it imperative to pay great attention to securing effective two-way communication between the Regional Committees and the Central Council.

Our business not medical education as such

76. We have explained that it is not our business to try to provide solutions to every problem of regulating the medical profession, but rather to suggest an administrative framework within which such problems can be solved. It is particularly important to bear this in mind in relation to medical education.

[1]See paragraphs 85–87.

We have received evidence from various quarters suggesting that particular medical subjects should be given more prominence in the curriculum. The Government's evidence referred to "a bias to medical education ill-matched to the needs of the community". Had we been prepared to accept it as our duty to look into such matters we might as well have recommended the replacement of the GMC by ourselves. The GMC is nothing, educationally, if it is not the forum in which the aims, nature and content of medical education are worked out. Consequently, if, for example, the Government believes that changes in the undergraduate curriculum would have a decisive effect in enabling it to discharge its duty to the community, then it should make this plain to the GMC.

77. There is only one respect in which, necessarily, we have had to set out views on medical education as such. This is on the general aim of each of the successive stages of medical education. We have felt it necessary to set out brief explanations of our view of each stage for two reasons. First, it is our view that because the stages of medical education are not co-ordinated, a good deal of fuzziness has crept into the definition of the aim of each stage. Secondly, it would not be sensible to set out views about what a doctor ought to be allowed to do upon the completion of each stage of education without having indicated broadly what that stage should consist of.

PART E: THE FUTURE CONTROL OF UNDERGRADUATE MEDICAL EDUCATION

The educational aim of the undergraduate period and its consequences for medical education

78. The aim of basic medical education ought to be to produce a graduate whose knowledge, skills, attitudes and potential are relevant to the medical needs of society. His understanding of human development, health and disease will have been established through the acquisition of knowledge of the appropriate sciences. He will have developed an appreciation of the complex aetiology of contemporary medical problems and of the services available for their management through academic courses and work with patients. His basic skill will be in clinical method. He will recognise the limitations of his own knowledge and abilities and will be prepared for a career in medicine that is based upon continuing education. All these are, in our view rightly, general aims and reflect first the recognition that all doctors will need vocational training before being able to practise independently, and secondly that the doctor must be given a sound basic training before specialising.

79. It follows from the general, and so necessarily limited, nature of the undergraduate course that the graduate should not be allowed to practise except under supervision. It is supervision by a doctor who, under our specialist registration proposals will be a registered specialist (that is, roughly, either a hospital consultant or a principal in general practice), that is so important. We consider that while the present legislation governing provisional registration reflects this generally, it is not in detail satisfactory, or indeed practical. The statutory provision insisting that the provisionally registered doctor should be required to hold a *resident* post is, we understand, no longer generally observed. We recommend that a careful study be made of the

precise rights which ought to be attached to provisional registration. We suggest also that the registration should be referred to as "restricted" rather than "provisional" as indicating more accurately the nature of the doctor's right of practice.

The control of standards of undergraduate education by the GMC

(*a*) *Formal powers*

80. We have set out[1] the existing powers of the GMC in relation to the control of standards of undergraduate education. We do not suggest any change in the GMC's power, subject to Privy Council approval, to withdraw its recognition from an examining body whose qualifying examinations do not meet the required standard. This provision is an essential consequence of the relationship between education and registration: the consequence of making the right to practise dependent upon a certain standard of education and training. Since it is the provision upon which the enforcement of a common standard on the licensing bodies in the last resort depends, it must remain.

81. The GMC's three inspectorial powers of visitation of examinations, of inspection of examinations, and of visitation of medical schools seem, for the reason set out by the GMC itself,[2] not to be very directly relevant to present-day arrangements for controlling medical education. We nevertheless believe that the powers should be retained. Circumstances can be imagined, either in relation to something which the GMC regarded as unacceptable in the plans of an individual medical school, or in relation to a new medical school, where the powers might be desirable or necessary—especially in view of the flexibility we propose that medical schools should have.

(*b*) *Informal powers*

82. We have explained that the informal aspects of the GMC's work in controlling the standards of medical education are probably the most significant aspects. That will no doubt continue to be the case.

83. One such informal method of control was specifically suggested by the GMC in evidence to us. While it "felt some doubt whether the formal kind of visitation and inspection which the Act contemplates would, if carried out generally, be a useful exercise in contemporary conditions . . . On the other hand . . . it might be useful to develop a less formal system of visits, possibly involving some members of the Council as visitors. This kind of informal visitation would be particularly useful if combined with other arrangements to collect, analyse and store information about developments in medical education which . . . are now being planned". We support this view: that is, the development of an informal visiting system and arrangements for the collection of information. We support also the calling of conferences of interested parties—including those receiving medical education—on specific topics. We have studied most interesting reports of conferences on methods of examination and assessment,[3] and undergraduate medical education,[4] and have no doubt of the value of this

[1]In paragraphs 34–36.
[2]See paragraph 35.
[3]Held February 1973.
[4]Held March 1972.

method of working. We recommend also that the external examiner system should be brought within the scope of informal methods of control. We have said already that, despite the absence of inspectorial visits, we believe the general standards of medical schools to be satisfactory and sufficiently uniform. We believe important reasons for this state of affairs lie not only in the good standing of the medical schools but in the crucial part played in their examinations by external examiners. We believe this to be such a vital element in maintaining standards that it should be recognised by the GMC, perhaps even by their approval of the appointment of individual external examiners, and certainly by their receiving regular, but brief, reports from these examiners. The GMC should take steps also to see that the external examiners are fully acquainted with the GMC's thinking about undergraduate education. We suggest that the GMC should, from time to time, convene conferences of examiners to discuss experiences, difficulties, standards, and medical education generally. We do not think that there need be any risk that external examiners will become objects of hostility on account of this new rôle: fears that this would happen seem to us to leave out of account the shared aim of the university and external examiners—the aim, that is, of securing the highest standard of medical education.

84. All this informal activity will culminate in the issue of advice by the GMC. The principal means of doing this must be by the periodic issue of recommendations. At present the GMC's recommendations appear at approximately ten-year intervals. The review of developments in medicine and thus of the undergraduate curriculum, should be continuous; thus, while the frequency of publication of advice will be for the GMC's judgment, such advice should appear more frequently than now. On the other hand, care will be needed that university curricula are not too often upset, and the GMC will no doubt accept that between the issue of recommendations and their implementation there may often be a time lag. We suggest also that curricular advice should not be too detailed, since undue prescription inhibits flexibility and could be counter-productive.

Central control of resources for undergraduate medical education

85. On the central control of resources needed for medical education, we noted some evidence put to us by the GMC suggesting that the GMC sought a rôle in the resource aspects of medical education. The evidence was as follows:

> "Both the powers of visitation and inspection and the power to require written information from Universities and Medical Schools are directed solely to curricula and the standard of examinations. They do not empower the Council to obtain information on other matters relevant to whether a Medical School is turning out good doctors such as (1) selection of students; (2) the number and quality of the teaching staff; (3) the adequacy of premises and teaching facilities, either generally or in relation to a particular size of student entry. The Council recommends that in any amendment of the Medical Acts its powers to seek written information and to appoint visitors and inspectors of schools and examinations should be widened so as to enable the Council to obtain and consider information on all matters relevant to the capacity of the schools concerned to produce good doctors and to the effectiveness of their methods of selection, assessment, and examination".

Although the GMC evidence refers only to information—gathering, and consideration of that information by the GMC, the question of the use to which the information might be put is clearly relevant.

86. The obvious risk of the proposal made by the GMC is that the GMC would seek to assume a rôle in relation to the selection of students and the suitability of staff and premises, which would damage the effective machinery already existing. The universities rightly regard the selection of students as their business, and it would be inappropriate for the GMC to seek to regulate the selection process. As to resources, it would in our view introduce a most undesirable possibility of conflict were the responsible body, the University Grants Committee, in its task of allocating scarce resources between universities officially exposed—to take the extreme example—to the implied suggestion that unless funds were channelled to a certain medical school, the school's degree would cease to be recognised for registration. Creation of what would amount to dual control over resources, especially considering the different responsibilities of the University Grants Committee and the GMC is not in our view the way to provide workable machinery.

87. The objection to be made to the GMC's having a *commanding* rôle in relation to resources does not extend to its having a *concerned* rôle. In particular the GMC should have access to information on the adequacy of staffing, buildings, and other resources; and it clearly has a broad general duty in regard to the balance between patient care, public welfare, and clinical teaching. In its work in relation to standards the GMC might sometimes properly point to the possibility of a university doing better with more resources. A ready channel for discussion between the University Grants Committee and the GMC seems to us desirable, and we believe that the possibility of providing for observers from the GMC to attend relevant University Grants Committee meetings and observers from the University Grants Committee to attend relevant GMC meetings should be carefully examined by the two bodies. It may be that in fact it is at subordinate committee level that contact could most usefully be made.

PART F: THE EMERGING CLINICIAN, FROM GRADUATE TO PRACTITIONER

The significance of the period

88. This part deals with the education of the doctor just prior to his receiving full registration under the present system, or general registration under the system we propose. Under both systems the doctor will, at the end of the period, be legally able to deal with any problems; and this demands that he shall have built on the knowledge, skills, and attitudes he acquired as an undergraduate by means of actual clinical experience and the exercise of increasing responsibility. Clearly it would not be expected that, when this training ends, the doctor would be capable of the highest skills in all branches of clinical medicine, but he must be able to put into practice the general principles learned in the undergraduate years and in particular, through experience in selected clinical specialities, to have practice in the understanding of people (crucial to diagnosis and management), in diagnosis, and in making decisions on clinical management. In other words the key to the period is the many facets

of consultation. It requires much contact with patients, because doctors learn best by doing. It also requires skilled supervision from doctors who really understand the aims of the training, and who are thus ready and able to help the graduate to learn constructively from his everyday practical experience.

89. This is as important a phase as any in the making of a doctor, requiring the same thought and supervision as the undergraduate years. In this part, therefore, we review the pre-registration year and explain why in our view it is an inadequate means to the end we have just stated. We examine the period of general professional training proposed by the Royal Commission on Medical Education, and conclude that it is an unsuitable vehicle for remedying the deficiencies of the pre-registration year. We propose the introduction of training which we refer to as *graduate clinical training*.

90. We regard it as essential that the GMC should define the detailed objectives of this training, and provide guidance on how those objectives are to be achieved—in particular on the development of legally independent responsibility. Naturally, also, we believe that the GMC must be provided with the powers necessary to ensure that the objectives are achieved and the guidance followed.

I: The pre-registration year

(*a*) *The nature of the education*

91. Pre-registration training consists in general of two successive six-month appointments in broadly based medical and surgical disciplines as a junior doctor in a "firm" headed by a consultant. The trainee is under supervision throughout the 12-month period, but is the hospital doctor of first contact for an appropriate number of patients for whose treatment he takes increasing responsibility. (There is legislative provision for pre-registration service to be done in midwifery or at an approved health centre. No health centre has, however, ever been approved for pre-registration service, and midwifery is now regarded as more appropriate to post-registration service.)

(*b*) *The framework of control of the pre-registration year*

92. The newly graduated doctor is *provisionally registered* and, as we have pointed out, this enables him to work only as a house officer in a hospital approved for pre-registration house officer service. The doctor is therefore under the control of working in an environment appropriate to his training needs. The doctor is also under the *supervision of a consultant* who, with the other members of the "firm", may be expected not only to supervise his work in the sense of ensuring that any treatment of patients is properly carried out, but also to provide instruction and general guidance. Responsibility for the doctor's development over the whole year rests essentially with his *university medical school*. Before he may proceed to full registration the doctor must provide a certificate of experience of completion of the pre-registration year from his university medical school; and the hospitals in which the year is spent must be approved by the university.

93. The only *statutory duties imposed on the GMC* in relation to the pre-registration year are of prescribing its length, the periods within it to be spent in medicine and in surgery, and the periods for which time spent in midwifery or in an approved health centre may be counted in lieu of time spent in medicine or surgery. The GMC's statutory powers are therefore very limited. The GMC has, however, been active in this area in an informal capacity. It included in its 1967 Recommendations as to Basic Medical Education certain recommendations on the pre-registration year such as criteria for the approval of posts. Furthermore, during 1972 the GMC convened two conferences on the subject, attended by representatives of all interested parties. The first conference discussed the various ways in which the present arrangements appeared deficient, the second studied the extent to which improvements might be made within the existing statutory framework. Consultations following these conferences led to the issue, by the GMC, of a Code of Good Practice for the pre-registration year. The purpose of this code (which was promulgated in January 1974 so that it is early to judge its effectiveness) is to improve placing arrangements, the maintenance of contact with the doctor's progress, and procedures for monitoring the suitability of hospitals and posts.

(*c*) *Criticism of the pre-registration year from those undergoing it*

94. While it is perhaps inevitable that there should be competition between service to patients and education of the doctor during the pre-registration year, it is plain that all too often the graduate is treated as a much needed extra pair of hands rather than a probationer doctor still requiring supervision and training at a significant point in his career. Some young doctors find themselves burdened with responsibilities they are not yet in a position to assume; others are given duties not necessarily relevant to their training needs. Following a study made among their number, the junior staff of the London Hospital sent the following evidence to us:

> "When the pre-registration year was considered (by us) only 5% felt that the regulation of this period was satisfactory, 76% considering it to be unsatisfactory. Examples of poor house jobs were given, the major problems being little consultant supervision and in-post training, especially where casualty work is concerned, and frankly unsuitable jobs because of specialisation. The service requirement of staffing National Health Service hospitals appears to be the overriding factor and there seems to be little evidence that the educational function of the pre-registration year has been considered".

The Junior Hospital Doctors' Association told us that "most posts appeared to be treated as service posts". A survey by the Association in 1971 showed that 45% of the house officers sampled lacked the immediate, experienced, registrar cover to call on if faced with an emergency foreign to their experience. Lack of adequate support varied but was more common in provincial hospitals. 42% of those sampled worked in excess of the recommended hours and 53% had responsibility for more than the recommended number of beds. This latter figure rose to 83% with covering of absent colleagues' patients which 48% of house officers did. In 85% of pre-registration appointments there was a failure to provide the time for study recommended by the GMC. The Medical Protection Society wrote that "in certain cases the degree of consultant supervision is barely adequate, and the range of duties of the appointment

places an excessive burden of responsibility upon the young doctor". The British Medical Association ascribed the considerable unrest among young doctors over this period of training as in part due to "the heavy pressures of NHS duties". In short, the doctors undergoing it are critical of the educational impact of the year; that is, of the posts available and of the quality of the teaching and supervision.

(*d*) *The organisational weaknesses which have led to the criticism quoted*

95. It is plain that young doctors are all too often attached to *consultants* from whom they do not receive the education the pre-registration year is supposed to provide. In some cases, this will be because the consultant is incapable of discharging the educational responsibility of the pre-registration year. In other—and very likely many more—cases this will be because the consultant has not received sufficient guidance on the educational task. Both of these difficulties ought, of course, to be remediable—by identifying the first group of consultants and providing guidance for the second.

96. That such difficulties are not remedied is in considerable part due to the equivocal position of the *university medical schools*. The control of the standard of instruction in the pre-registration year rests primarily on the power conferred on the medical schools to approve hospitals for pre-registration service. The medical legislation confers this power with the evident intention that a good standard of education will be secured by the medical school refusing to approve any hospital *not* providing a good standard. Clearly the effectiveness of such a provision depends on there being a demand, from NHS hospitals, for doctors just out of medical schools. On the whole the medical schools have been supplicants and have had to recognise unsuitable posts in order to absorb their output of doctors. The increasing number of doctors graduating has tended to aggravate this situation. A specific weakness of the present arrangements is the legislative reference to "hospitals". Since the pre-registration year was introduced, medical schools have found it essential, as well as approving hospitals, to identify in each approved hospital particular *posts* as acceptable for pre-registration experience. In evidence to us, the British Medical Association suggested ". . . that there must be laid upon the new regulatory body a definite obligation to see that all pre-registration posts comply with requirements with a reserve power to withdraw approval from individual posts which do not do so". Although, as will be seen from our proposals, we do not wholly subscribe to this sort of remedy, we agree with the implicit diagnosis that a greater organisational concentration is required on the identification of posts suitable to the education involved. A further specific weakness is that the medical legislation in effect provides that if a medical school is assured that the doctor has satisfactorily served the prescribed periods in medicine and surgery in an approved hospital it *shall* grant him a certificate of experience. There is therefore no sound basis for action by the medical school to induce students to seek employment in posts which are, from an educational point of view, satisfactory both in themselves and in combination. In this connection it may be noted that the Royal Commission on Medical Education recommended that the medical legislation be amended so that a medical school should not grant a certificate of experience unless

it was satisfied that the graduate had held two posts which were not only adequate in themselves, but, in combination, provided suitable experience. The GMC has endorsed this proposal. The universities have been much criticised over the pre-registration year; we hope we have shown that the legislative framework within which they have worked is deficient.

97. If the universities have responsibility for, but inadequate power over, the pre-registration year, then the *NHS* has the power but no specific responsibility. In practice virtually all pre-registration training takes place within the NHS. A great deal of effort is expended through many *Regional Postgraduate Committees* trying generally to improve pre-registration training and particularly to identify posts which are suitable from the point of view of training and supervision. This machinery, very valuable though we believe it to be, can hardly be expected to work well in relation to pre-registration training when responsibility for that training is so inadequately apportioned. It is rather like expecting the pipe to do the work of the pump.

98. The lack of a clear apportionment of responsibility is evident when *central control by the GMC* is examined. The GMC put the following evidence to us:

> "To secure improvement in this matter requires the co-operation of many different authorities. These include the Universities and Medical Schools, the National Health Service authorities responsible for the grading of posts and the provision of residential accommodation, and the attitudes of the consultants who supervise the young doctors when in these posts. In the opinion of the Council it may be doubtful how far in such circumstances the creation of new statutory powers would be effective. It is, however, desirable that one Central Body should be charged with a responsibility to review on a national basis matters relevant to the educational value of the pre-registration year and, where deficiencies emerge, to make representations to the various Bodies who can effect improvements".

While, as will be seen, we do not share the GMC's view about the undesirability of new statutory powers, we agree wholeheartedly with the sense of this evidence—and in particular for the need for a firm grip to be taken of the educational task.

(*e*) *Our view of the pre-registration year*

99. A summary of the evidence we received on the pre-registration year is that it is in many respects unsatisfactory: there is inadequate definition of the aims, inadequate understanding of the proper interaction of service and education, and inadequate organisation and assessment of the working of the system. What is needed is a more effective recognition that the young doctor is at a stage where his further education takes the form of a supervised exposure to responsibility. The quality of the supervision and the determination of the degree of responsibility are alike important, and the seriousness of the educational task must be recognised: in our view this requires a new approach and a new organisational structure.

II: General professional training

(*a*) *The origin and nature of general professional training*

100. The Royal Commission on Medical Education suggested that, after the pre-registration year, every doctor should undergo three years of general professional training followed by a period of further professional training varying in length according to the particular specialty. This section is concerned with whether general professional training does, or might, remedy the inadequacy of concentration on the task of making a clinician of a medical graduate.

101. The Royal Commission's proposals for general professional training were as follows. It was suggested that the doctor would progress through a series of carefully selected six to twelve month appointments. Increasing clinical responsibility would be conferred and the doctor's specialist inclinations taken into account. For each specialty some types of appointment would be essential, others optional; many would be equally appropriate for a number of disciplines, allowing the doctor to change course and still be credited with appropriate earlier periods of training. Variety in the type of appointment would be an important feature—posts would not be confined to the hospital setting but extend to general practice, research, administration and, for potential teachers, academic appointments and courses. The aim of general professional training and its place in the educational process as a whole were not discussed very fully in the Commission's report; but it was particularly the idea of designing a system where posts would give relevant experience for a variety of specialties which encouraged the belief that general professional training involved a real attempt to tackle the need for a more serious and a more organised approach to the clinical training of young doctors.

(*b*) *The outcome of the Royal Commission's proposals on general professional training*

102. We do not believe that general professional training has turned out to provide the opportunity for obtaining a variety of clinical training appropriate to several specialties. Indeed, the absence of comment on or proposals for the period in the evidence we have received inclines us to conclude that not a great deal has come of the Royal Commission's proposals. What passes at the moment as general training is probably as much the natural course of development of higher training as a deliberate adoption of the Royal Commission's ideas. The lack of special arrangements for the organisation of general professional training suggests that it has never really been accepted as an educational concept in its own right. It is clear that no effective mechanism is operating to control general professional training and to co-ordinate it with what has gone before and what will come after.

103. A good deal of feeling is evident over the apportionment of blame for the failure of the expectations that existed of general professional training. It has been suggested that the universities missed the opportunity to improve substantially the postgraduate education of doctors. To this the universities would reply that they were given neither standing nor resources to act. The lesson we draw is of the necessity of good arrangements for the control of this stage, as of all other stages, of education.

(*c*) *Our view of general professional training*

104. We have, as we said, looked at general professional training principally with a view to discovering whether it does, or might, remedy what we regard as the present inadequate concentration on the educational task of making a graduate into a clinician. In our judgment it does not and could not do so.

III : Graduate clinical training

(*a*) *The nature of graduate clinical training*

105. We have already set down[1] our views on what must be the broad educational aim of graduate clinical training. The training lies, educationally, between graduation and the beginning of specialist training and, in terms of registration, between the student and the doctor allowed to practise without supervision—the broad educational aim must, therefore, be to make a generally trained clinician of the medical graduate. We suggest the new title not only to get rid of the apologetic implication of "pre-registration year", suggesting as it does that this is a year that has to be served waiting for full registration, but also to stress the nature of the education required.

106. We recommend that graduate clinical training comprise a series of posts providing a wide range of general clinical experience and suitable for the development of responsibility. In this respect the nature of what we recommend does not greatly differ from the nature of the pre-registration year or of general professional training. We believe that graduate clinical training experience should be wider than that accepted for the pre-registration year and thus might include *some* specialty work. The emphasis should not, however, be specialist experience as it apparently is in general professional training now.

(*b*) *The importance of adequate control of graduate clinical training*

107. It will be evident from our criticism of the pre-registration year that what we believe to be crucially necessary is a sound organisational approach to graduate clinical training. We consider this in relation to the control of standards of individuals, the control of resources, and the control of overall standards.

(*c*) *The control of standards of individuals*

108. The responsibility for controlling the education of individual graduates of United Kingdom medical schools during graduate clinical training should normally rest, we recommend, with the university from which he graduated. For graduates of medical schools outside the United Kingdom, or those possessing only diplomas of examining bodies other than their medical school, responsibility must be with the university in whose NHS Region the training post is held.

109. There needs to be a much closer overall supervision of trainees than exists at present for the pre-registration year, and we recommend that the universities be given the resources to set up a tutorial system by which individual

[1]In paragraph 88.

trainees are personally guided and advised by members of the medical faculty. Not only would such a system allow careful and continuous supervision of the doctor's progress towards the goals of this stage, but the adequacy and suitability of the posts he occupied would also become evident. As a corollary, we believe that the provisions governing the issue of certificates of experience of graduate clinical training should be such as to give the university standing to insist, in the last resort, on a certain pattern of experience.

110. We believe that the assimilation of knowledge and skills during this stage, just as for every other stage of medical education, ought to be assessed; and because we believe this, we recommend that full registration should be accorded only to trainees assessed as satisfactory. The sort of experience which graduate clinical training will provide will be difficult to test by a once-and-for-all examination, but there are other methods. We believe that the GMC should study this problem with a view to establishing clear criteria of assessment for the universities.

111. We recognise that our recommendation will mean that some young doctors may have to accept deferment of full registration. We hope that such cases will be rare and we believe that the universities can do a lot to ensure they are rare by paying even more careful attention than they do at present to the assessment of undergraduates and in particular to the swift identification of students showing themselves to have no aptitude for clinical work.

(*d*) *Central control of resources for graduate clinical training*

112. We have mentioned that the task which we recommend to be placed on the universities in relation to graduate clinical training will require tutorial and administrative resources. We regard it as essential that the universities are enabled to recruit those tutorial and administrative resources from extra provision, through the University Grants Committee by the Government. It is no good supposing that the sort of supervision of graduate clinical training which we are advocating can be achieved by spreading the existing butter more thinly. If it is argued that such resources are not required because the universities already have a similar responsibility in relation to the pre-registration year we would reply, and would urge the universities to reply, that they have exercised that responsibility—no doubt because of a lack of resources—ineffectively.

(*e*) *Local control of resources for graduate clinical training*

113. The period immediately following graduation is difficult for the young doctor. When he was in the medical school his education was carefully supervised by his teachers. A few years after graduation and he will have acquired experience as well as a certain position. A risk which we have mentioned in relation to the pre-registration year is that the young doctor will be used just as a pair of hands. Another risk is that he may end up working under a consultant who for various reasons may be poor at passing on his own knowledge and skill. We believe that machinery is needed to ensure that these and other threats to the educational process are coped with. We have already stated our belief that those receiving graduate clinical training should be in close touch with the university medical school educators. In turn the university

educators should be in close touch with the consultants doing the teaching and with the NHS authorities. The machinery for achieving this already exists in the Regional Committees established in association with the Postgraduate Councils. In our view the Regional Committees should regard it as their particular responsibility to ensure that graduate clinical training posts are posts which contribute fully to making a clinician of the graduate.

(f) Control of overall standards of graduate clinical training

114. We believe that the GMC should control the overall standards of graduate clinical training to the same extent and in broadly the same way that it controls undergraduate medical education. First the GMC should have the power to refuse to recognise a university's certificates of completion of graduate clinical training. We do not mean that the GMC should have the power to refuse to accept a certificate of experience in the individual case. Just as in the undergraduate field the GMC does not question an individual's degree award the graduate clinical training experience of any individual ought not to be a matter of argument. We are referring to the implicit power of the registering body to determine what it will accept as conferring the right to registration. Although this *is* the implicit power of the registering body, we have hesitated over this specific recommendation. The reason for our hesitation is that the university will not have direct control over the conditions of the graduate clinical training, which will take place largely in NHS posts, in the way that it controls undergraduate education. Nevertheless, we believe that this reserve power—unlikely to be used except in the last resort just as the GMC's power to refuse to recognise an undergraduate qualification has only rarely been used—will underline the prime responsibility of the universities to ensure that graduate clinical training makes its full contribution to the education of the doctor. We therefore recommend that the GMC should be enabled by the medical legislation to refuse to accept a university's graduate clinical training in the same way, and subject to the same sort of safeguards, as it can refuse to accept a university's primary qualification.

115. We recommend that the GMC should have reserve powers of inspection in relation to graduate clinical training. We have reached this conclusion after taking account of the evidence on the pre-registration year which we have recounted[1], and of the fact that such a power may be regarded as the parallel of the powers of inspection the GMC has in relation to undergraduate education. We believe that the universities ought to take action, through the machinery we recommend, if a post is unsatisfactory, but it may sometimes be desirable that the possibility of GMC intervention should be a background to their action.

116. Just as for the undergraduate period, we see the GMC's control of graduate clinical training working primarily through its position as the central and respected body for medical education, using to the full the informal methods it has already effectively developed. Specifically, we believe that the GMC's central responsibility for graduate clinical training should be statutorily recognised in such a way as to ensure its right to be listened to by the NHS authorities on matters connected with graduate clinical training.

[1]In paragraph 94.

(g) The length of graduate clinical training; the possibilities in a system where the GMC has an overall co-ordinating function

117. We believe that all the arguments—albeit arguments rather outside our sphere of responsibility about the *nature* of medical education—point in the direction of making graduate clinical training last something like two years. This would be achievable were the undergraduate course to be correspondingly reduced in length. Indeed we believe that such a change would allow a better balance between clinical and other teaching and facilitate greater curricular flexibility. It would also lead to doctors receiving a salary earlier than at present.

118. Although we are not recommending that graduate clinical training should be extended at the expense of the undergraduate course, we recommend that the possibility be carefully studied. In particular, once it is seen that graduate clinical training is educationally effective, we expect a great deal of support for the possibility we have mentioned.

119. The course we recommend leaves open the option we have mentioned. We recommend that the length of graduate clinical training should be a matter for specification in regulations made by the GMC.[1] Of course the GMC would consult very widely before making such regulations. The medical legislation does not require that the undergraduate course should be of a certain length. On this basis, it would not involve the delay and difficulty of an Act of Parliament to shorten the undergraduate course while lengthening graduate clinical training. Much the same possibility as we have just described exists now in relation to the pre-registration year and the undergraduate course; but an overt recognition that it is a responsibility of the GMC to co-ordinate all stages of medical education would, we believe, encourage greatly the consideration of such changes.

120. The recommendation we have just made is of course a prime example of the sort of change that would be possible under a system where all medical education is organisationally—not just vaguely thought of as—a continuum. Once such an organisational change is achieved the possibilities are many and exciting. One possibility is that graduates of particular universities might be required to obtain particular experience during their graduate clinical training. The point of such arrangements would lie in the conferment of extra flexibility for universities in the organisation of the undergraduate course. The subjects which were to be provided for during the graduate clinical training could be dropped from the undergraduate curriculum to allow a greater concentration on others. Another possibility is that of allowing those graduates who wished to enter a non-clinical specialty, for example biochemistry, to proceed direct to specialty training. If such a person decided later on that he wished to change to a clinical specialty he could complete a period of graduate clinical training at that time. The consequences of these two proposals for registration, in the sense that registration defines what the doctor is allowed to do, would naturally have to be considered most carefully.

[1]Just as the GMC is empowered to prescribe the length of the pre-registration period of training at the moment.

(*h*) *Envoi*

121. We reiterate here what we believe to be the crucial factor in relation to this period of education: the need for graduate clinical training, more than any other stage of education, to be soundly organised. No amount of exciting prescriptions of what this education would consist of can be a substitute for the hard task of setting up and maintaining effective machinery to ensure that young doctors obtain the full benefit of clinical education.

Registration following graduate clinical training

122. We recommend that on completion of graduate clinical training the doctor should receive *general registration*. Except in name, this will not differ from the legal status conferred at present by full registration. The generally registered doctor will be able, just as is the fully registered doctor now, to set up in independent practice. Neither do we propose any amendment of the legislation affecting the employment of doctors by the NHS, so that under our proposals the generally registered doctor will be capable of being employed anywhere in the NHS. General registration under our proposals will be the registration required by law in relation, for example, to the drugs legislation, and to the issuing of a variety of certificates required under a wide range of legislation.

123. We believe that in practice general registration will, as compared with the present full registration, decline in importance so far as the *recognition* of doctors is concerned. This is because our proposals include the establishment of an indicative specialist register. We discuss the results we expect from the establishment of a specialist register later.

124. Mention of the function of registration as "recognising" the doctor and of defining what he can do prompts an explanation of our view of the development of clinical responsibility. A formal, or legislative, system defining the exercise of responsibility clearly has to be in stages. The fact that a staged system is necessary does not, however, make it any less of an artificial imposition on the process of developing the ability to exercise responsibility. A staged system will mean that some doctors will be restricted from taking responsibility which they are capable of taking. Others meanwhile will have the opportunity to exercise a responsibility which they are not fully capable of discharging—though it has to be remembered that in this case they will generally be under supervision. The exercise of responsibility—even, or perhaps especially, a responsibility which may quite literally involve life or death—cannot be learned without actually exercising responsibility, and we believe it is necessary to encourage the development of responsibility by conferring it. We believe there to be three generally recognised and recognisable stages in the development of clinical responsibility: namely practice under supervision; independent practice; and practice carrying ultimate responsibility for the care of the patient, that is, at a high specialist level. These stages correspond broadly to the three stages of registration we propose: restricted registration, general registration, and indicative specialist registration.

PART G: SPECIALIST EDUCATION

The nature of specialist education

125. Specialist education should complete the education of the doctor by providing the knowledge and skills of the particular specialist discipline to the point where the doctor is competent to take the highest level of clinical responsibility for patients requiring the relevant specialist treatment. The specialist phase of medical education, unlike the undergraduate or graduate clinical training phases, does not proceed to a roughly equivalent point for all students. The detailed aims of specialist education must therefore be determined in relation to each specialty.

126. Specialist education covers a wider range of learning than any other phase of medical education. What is common to practically all specialist education is a series of appointments while the doctor prepares himself for the membership or fellowship of the appropriate Royal College or Faculty. If these goals are obtained the doctor holds a further series of appointments. During all this time the doctor will wish, or need, to attend courses which may last a few days, or weeks, or months. Evidence of ability to pursue independent research may be required.

127. We have already pointed out that the proposals of the Royal Commission on Medical Education relating to general professional training and higher training represented an approach to structuring specialist education. In our view, however, the Royal Commission's proposals could not do, and certainly have not done, more than provide a frame of reference. Nevertheless, following the Royal Commission's report, the organisational development of specialist education took several important steps forward.

128. This was particularly so in the field of hospital specialties with the emergence of the Joint Committes on Higher Training. Joint Higher Committees existed, at the time we made a count, for 17 medical specialties, nine surgical specialties, and the specialties of obstetrics and gynaecology, community medicine, anaesthetics, and psychiatry. The constitutions of the Committees vary but the common factor is wide representation of the interests involved in the specialty. The Joint Committee on Higher Medical Training, for example, represents the four Royal Colleges of Physicians in the British Isles, the specialist associations in the medical specialties, the Association of Professorial Heads of Departments of Medicine and Paediatrics, the Faculty of Community Medicine, and the Conference of Postgraduate Deans of the United Kingdom. Within certain specialties Sub-Committees are established for what may be described as "sub-specialties". Before the establishment of the Committees a specialist's training plan was determined primarily by himself. The Joint Committees have changed this to a considerable extent, making their work the definition of specialist education for each specialty. They establish criteria for posts and inspect them, recommend patterns of appointments, and list useful courses and higher qualifications. The endpoint is accreditation as a specialist by the appropriate Joint Committee. In the rest of this part we use the word "accreditation" to mean accreditation as a specialist giving entitlement to specialist registration. As we have said earlier, we have found it helpful to

think of accreditation as being to specialist education what finals are to undergraduate education. Increasing numbers of doctors are being accredited by the Joint Higher Committees.

129. The situation in general practice is different. The profession has only recently decided to introduce specialist training for general practice. Implementation of the programme is now under way and by 1977, it is estimated that there will be sufficient programmes available for every future general practitioner. Since these programmes are of three years' duration it is anticipated that by 1980 principals appointed in the NHS should normally have completed a full programme of training. The Postgraduate Training Committee for General Practice, the equivalent of a Joint Committee on Higher Training, has been established to approve training programmes and is inspecting and recognising teaching practices. There is no doubt in our mind that what we have to say about specialist education applies to the education of general practitioners. The evidence we received from the Royal College of General Practitioners demonstrated in considerable detail that general practice requires specific knowledge and skills just as do other areas of practice. It follows that we believe there to be a need for specific specialist training in general practice, and that general practice should be recognised as a specialty on the specialist register which we propose. It follows also that the standards of general practice ought to be maintained in the same manner and to the same degree as other specialties.

The GMC's rôle in specialist education

130. We recommend that the GMC should control the standards of specialist medical education as it controls the standards of undergraduate medical education. We recommend that this control be brought about through the GMC maintaining a specialist register.

131. Our establishment as a Committee may be said to have resulted partly from suspicion of the GMC's plans for the organisation of specialist education following the Report of the Royal Commission on Medical Education. It soon became clear to us that a large part of the difficulty that had arisen over the GMC's plans for the organisation of specialist education arose because of widespread misunderstanding of the relationship between education and registration. In particular, we refer to the fact that any registration system must ineluctably involve the registration body in the control of the standards of the education conferring a right to registration. Supposing that relationship between education and registration to be established, we regard it as undesirable for us to attempt to formulate detailed organisational plans. More satisfactory arrangements are likely to result if they are worked out in the give and take of wide consultation following the publication of our report—with the GMC taking the lead in such discussions and the Government standing ready to co-operate, particularly over any necessary legislation. Our recommendations are therefore general in character and will require to be supplemented by detailed discussion among interested parties.

132. We look first at the control of the standards of individual doctors, and then at the way that what we suggest fits in with the powers we believe the GMC ought to have.

The control of the standards of individuals

133. Our *prediction* is that most accreditation will be by the Royal Colleges and Joint Higher Training Committees. We regard it as very important that the GMC should build upon the foundation of their work, and indeed the work of other interested parties in the field, rather than pursuing some ideal solution unrelated to recent developments. Our *recommendation* is that accreditation should rest in the hands of any body to which the GMC is willing to give that responsibility. Just as in other fields of medical education, it is important that, within a firm framework of overall control of standards, diversity and experiment should flourish and vigour not be lost.

134. There is in our view no doubt that wide-based and widely-ranging discussions ought to be opened as soon as possible on the allocation of the power of accreditation and associated problems. We have remarked that the state of specialist education now may be likened to the state of undergraduate education in the mid-nineteenth century. But really it is more complicated than that, not only because of the diversity of the educational task involved, but also because of the number, and diverse corporate standing, of providing bodies.

135. We recommend, as a first step, the calling of a conference of all interested parties. We recommend a conference because that seems to us the most appropriate means of arriving at agreement on the broad approach while noting any particular problems. We are conscious that, in the prevailing organisational state of specialist education, all sorts of special arrangements have grown up to cope with special problems. Any attempt to list these problems, or even the principal of them, is outside our province, but we cite a general and a particular example. A general problem is the extent to which plans for specialist training have been adapted to take account of the recommendation of the Royal Commission on Medical Education that postgraduate education should consist of an intern year, three years' general professional training, and a further period of specialist training. An example of a particular problem is that one Royal College has established what it regards as an exceedingly valuable control over general professional training posts for doctors wishing to follow the specialty with which it is concerned. Having established such a control, the College would naturally object to losing it through some central and insensitive disposition of the power of accreditation. Evidently the problems are daunting, particularly because many of the bodies concerned with specialist education are jealous of their particular standards and their particular approach. We can only hope that our report, and in particular parts B and C of this chapter, will persuade the profession of the desirability of tackling resolutely the task of organising specialist education.

The GMC's powers in relation to specialist education

(*a*) *Formal powers*

136. We have recommended that accreditation should rest in the hands of any body to which the GMC is willing to give that responsibility. It follows that the GMC must have the power to refuse to accept a particular body's

accreditation as providing an assurance of competence sufficient to merit registration. Such a power is an inescapable consequence of the introduction of specialist registration.

137. We have said that the agents for the provision of specialist medical education, and thus the controllers of the standards of individuals, should be the Joint Higher Training Committees, the universities, the Royal Colleges, or indeed any body or combination of bodies with which the GMC is prepared to see such responsibility rest. Some of these bodies, and particularly of course the Joint Higher Committees, do not at present have an established corporate identity. If it is thought desirable to circumscribe the power of the GMC to reject a body's accreditations, it will probably be necessary for them to establish a corporate identity. In the undergraduate field the agents of education can be listed in legislation and any rights they ought to have can be entrenched in that legislation. Specialist education does, however, develop in a way that pre-specialist education does not: new specialties develop and existing specialties decline in significance. We believe that the consequence of this for the control of standards of specialist education is that any legislative restriction on the GMC's power of recognition of accrediting bodies should not be too rigid. We suggest therefore, that it would be desirable for the GMC to be able to recognise an accrediting body without primary legislation.

138. We recommend that the GMC should have a general and widely-drawn power to send for those papers of accrediting bodies relevant to accreditation. Thus it would be possible for the GMC to insist, not only upon receiving full general details of the accreditation requirements for accrediting bodies, but also details relating to the accreditation of individuals. The importance of being able to send for general details is not perhaps very great, because such general details will be part and parcel of the general dialogue taking place between the GMC and the accrediting bodies. Details concerning individuals might be important because of the need to ensure that fair standards were being applied to the consideration of individual experience—for example, experience gained overseas.

139. Accreditation will no doubt depend to a considerable extent on satisfactory completion of relevant experience. It is in relation, particularly, to deciding what experience is "relevant" to accreditation that there may be a need for a mechanism for appealing to the GMC against an accrediting body's refusal to grant accreditation. The registration schemes of certain overseas countries include such provision—the scheme operating in the Netherlands might merit special study.

(*b*) *Informal powers*

140. We believe that, as for every other stage of medical education, the most important aspect of the GMC's control over specialist education will be its informal aspect: the issue of recommendations, the calling of conferences, the general work of advice and encouragement. We mention some of the areas in which we expect the GMC to be active in the next paragraph.

141. We believe that the accrediting bodies must be induced to co-operate closely over the interchangeability of experience so that specialty programmes have as many crossover points on them as possible. This is essential for doctors at an early stage of specialist training who may want to change specialties, and no less important for the NHS which must have flexibility in the use of junior specialist training posts. The GMC must also grasp the nettle of the relative complexity of specialties. Some specialties do not require such lengthy training as others and the arrangements for accreditation should recognise this. A third point is that since every applicant for admission to the specialist register will have to be individually assessed—it is an integral part of the educational process—the methods to be used, such as examination, continuous assessment or a combination of both, will have to be settled for each specialty and the standards used will have to be harmonised as far as possible.

142. Lastly we mention a point which is particularly important to the efficient use of the skills of women doctors. This is that the arrangements for accreditation and thus specialist registration should be flexible enough to allow training on a part-time basis.

143. We discuss briefly in chapter 3 the acceptance of specialist qualifications gained overseas.

The provision of resources for specialist medical education

144. As a prologue to this section, we stress that our suggestions are firmly rooted in our views of the role of the Postgraduate Councils and the Regional Committees associated with them.[1]

145. Specialist education consists in very large measure of training within the NHS. Apart, therefore, from the provision of facilities such as lecture-rooms and libraries, a principal need is to ensure simply that the service provision is greater than the service load itself requires. The necessity is not for the provision of teaching staff as such, but for there to be opportunity and incentive for the ordinary staff—who are the teachers and the taught—to engage in discussion, in formal and informal tutorials and lectures, and in clinical and other research, as well as in attendance at courses of instruction and meetings of specialist societies. We know that the NHS—in accordance with statutory duty—willingly accepts in principle the responsibility we have described: at the same time, the needs of patient care are immediate, constant, and inescapable; and they constitute the most direct statutory responsibility. There is, moreover, a universal tendency for service demand to increase in line with any increase in the resource provided. There is therefore a strong case to be made out for some mechanism, both central and local, which will protect all concerned—the supervisors and teachers as much as the supervised and the taught—from a total immersion in their day-to-day tasks. We received some particularly interesting evidence from the Scottish Council for Post-graduate Medical Education on this subject. The constitution of the Council allows for two members nominated by the Scottish Home and Health Department, and in practice the most senior members of the Department's lay and

[1]See paragraphs 71–75.

medical staff have filled these places. We were assured on all sides that the resulting dialogue had contributed much to the availability of resources for specialist education.[1] We commend further study of the problem to the GMC, to the Postgraduate Councils and to the Departments, drawing attention to the apparently proven value of continuous working contact between the Departments as providers of resources, the colleges and universities, and those who provide and receive specialist education. We suggest, too, that it would be helpful if it were more generally accepted that there is an inevitable, and entirely blameless, conflict between education and day-to-day care; and that a central mechanism is needed if a satisfactory balance is to be struck.

146. We believe that the formal responsibility for the quality of training posts must rest with the accrediting body in each specialty, acting against the background of the GMC's reserve powers we have recommended.[2] As the other necessary element in the control of resources for specialist medical education, there must, however, be an efficient local mechanism concerned with the identification of suitable posts, and with matching posts to training requirements. We have already explained[3] that we consider that this sort of process can take place only in an atmosphere of co-operation and goodwill such as we believe to exist within the Regional Postgraduate Committees.

Registration following specialist education.

147. Completion of specialist education and accreditation by the appropriate body will mark the doctor fit to take the highest level of clinical responsibility in his chosen field. His registration will reflect this; but we do not believe it ought to confer some legal status above that conferred by general registration. We develop our views on registration following specialist education in the next part of this chapter.

PART H: SPECIALIST REGISTRATION

148. As a preliminary to this part, we wish to recapitulate our reasons for recommending a specialist register. We believe that every doctor should have received a specialist education: a specialist register will, on the whole, secure that a specialist education is a pre-condition of the independent practice of medicine. A specialist register is also desirable as conferring power on the GMC to fill, in the field of specialist education, an equivalent rôle to its supervision of undergraduate education. Furthermore, since the supervision of all stages of medical education will be in the hands of one body, the co-ordination of the planning of all medical education will be possible.

Our specialist registration proposals

149. This part sets out our arguments for recommending an *indicative* specialist register. We call it indicative because all it does is indicate: it does not reserve particular areas of medical practice to registered specialists in the

[1]We recognise that the difference in size of Scotland from England and Wales and the comparatively generous staffing in Scotland may contribute to the apparent effectiveness of the Scottish arrangements.

[2]In paragraph 136.

[3]In paragraphs 74 and 75.

way that medical practice as a whole is reserved to those fully registered under the present system. We come to this conclusion basically because, since an indicative register provides a public means of recognising the qualified doctor, in the long run it produces the same result as a restrictive one.

150. We set out our arguments in detail, and they may often appear tryingly theoretical, raising possibilities that no man of sense would for a moment entertain. Specialist registration does, however, cause much misgiving within the medical profession and this has strengthened our general resolve to argue rather than just prescribe.

The case against a restrictive register

151. A registration system could be made restrictive through provisions *external* to the formal registration system. Legislation at present ensures that the NHS provides the services of only those medical practitioners who are registered. The relevant legislation could be amended so that certain types of appointment were reserved for doctors with the appropriate specialist registration. This seems to be the prospect which most doctors fear, and we return to it.

152. Theoretically there are three ways in which a medical registration system could *of itself* be made restrictive. First, what the registered person might do could be defined in terms of the difficulty of the task: thus the lowest category of registered doctor would be permitted to deal with only a common cold while typhoid would require the attention of the highest category of registered practitioner. Secondly, the treatment of certain conditions might be reserved to certain doctors: thus the heart specialist would be allowed to deal only with the heart and the lung specialist only with the lungs. Both these approaches are plainly impractical as they would cause absurd difficulties in diagnosis, defining the seriousness of the condition diagnosed, and dealing with emergencies. It is important in relation to what we have said about three levels of *responsibility* in the practice of medicine, to recognise that it is one thing that generally understood limits of responsibility should exist, another altogether that those levels of responsibility should be defined precisely enough to enable the creation of restrictive legislative rules. Thirdly, a registration system might be made restrictive by providing that a doctor might not practise save under supervision. This is quite practicable and indeed is embodied in the present GMC system in that the provisionally registered doctor is allowed to practise only in a restricted environment. Evidently, however, there can be only two levels in such a system: supervised and unsupervised.

153. That there can be only two grades of registration defined restrictively is a conclusion of considerable importance in relation to our proposal for a three grade registration system, because it immediately poses the question of whether more than one of the three registration grades should be included in the "lower" restrictive area; or, in other words, whether every doctor should be kept under supervision until he obtains specialist registration.

154. The case *for* a restrictive specialist register is that it is the most effective means of securing that every doctor has received a specialist education: if

independent practice were not allowed without specialist registration the doctor who wished to practise independently would have to undergo specialist education. If, therefore it is believed—as it is by us—that every doctor ought to have received specialist education then it is logical to introduce a restrictive specialist register.

155. We believe that the length of time which would elapse before a doctor achieves specialist registration under our proposals rules out the application of strict logic. It is not only that doctors would object vehemently—and rightly—to being kept in a state of supervision for 10 years or more from the start of their undergraduate course. It is that it would not be sensible to set up a system which would be all too likely to ingrain the habit of passing responsibility to others: the development of responsibility depends, as we have pointed out, on the conferment of responsibility.

The consequences of an indicative register

156. Indicative specialist registration will undoubtedly have a very large effect. In the nineteenth century the unqualified practitioner largely disappeared once the public was enabled to recognise the qualified man.

157. In the NHS, the effect of introducing a specialist registration system will at first vary according to the supply and demand situation in the particular specialty. In many hospital specialties the competition for senior appointments is very keen. It is obvious that in such specialties it would immediately become essential for aspirants to obtain the necessary specialist registration, simply because in any choice between two candidates, one having the appropriate registration and one not, preference would be bound, save in the most exceptional circumstances, to be given to the candidate with the appropriate specialist registration. The situation would be different where there was a shortage, for example in relation to geriatricians or, in some areas of the country, general practitioners. Eventually, however, the pressure will tend in the direction of requiring doctors to have the relevant specialist registration, if only because the public, through the NHS authorities, will insist that they are provided with the services of registered specialists. Thus public insistence will create its own pressure on the supply and demand situation.

158. We believe specialist registration will work through indicating the specialist educated doctor by whom the public will wish to be treated. We do not therefore favour the possibility of making the registration system restrictive by the external method of reserving certain levels of appointment within the NHS to registered specialists. Nevertheless we should not like to rule out the possibility entirely. It will be clear from the previous paragraph that such a change would be wholly superfluous in many hospital specialties because competition for appointment is so acute. That cannot be said of general practice, and there are many general practitioners who would like to see only those who had received appropriate specialist training in general practice being allowed to practise as principals within the NHS. In this connexion we mention again the commitment of the medical profession that every doctor wishing to be a principal in general practice shall have received three years vocational training.

159. So far as the private sector is concerned, it is again clear that in the long run, because they have been provided with a means of recognising the highly qualified doctor the public, through their general practitioners in the case of hospital specialists, will select his services: in other words they will pay only for the registered specialist. This tendency will be reinforced by the proposals we make in the next section.

Protecting the status of the registered specialist

160. In our view the titles of registered specialists, that is to say whatever indication becomes customary to show that a person is a registered specialist, should be protected so that action would be taken against a doctor who pretended to have a particular specialist registration which he had not. This action would be similar to that which is taken now against laymen pretending to be registered[1], a matter which can be dealt with only by the general law of the land.* A doctor falsely pretending to a specialist registration could, and in our view should, be dealt with by the GMC. The likelihood of such cases is remote since any doctor pretending to a specialist registration he did not possess would be well aware that he was committing a fraud.

161. We regard the consideration of two other possibilities as something for the GMC in consultation with the medical profession, following the establishment of a system of specialist registration. That is, that it might be regarded as a professional offence first to practise in a field in which one lacked the relevant specialist qualification, and, secondly, consistently to refer patients for specialist treatment to non-specialists. It will be evident from our discussion of the means of making a registration system restrictive that we do not believe that medical practice can be divided into compartments. It follows that, save in very limited circumstances, it would not be possible to treat as offences the two courses of conduct just described. Nevertheless there may be some circumstances so blatant as to sustain a charge that the doctor is behaving unprofessionally. For example, a doctor without the appropriate specialist registration might be consistently performing operations in circumstances—including his own lack of training—which made the risks entirely unacceptable. Or again two doctors might be constantly referring patients to one another purportedly for specialist opinions which neither was capable of giving. These matters, which are closely related to some aspects of fitness to practise, are in our view for the GMC and for the profession to consider.

PART J: MISCELLANEOUS

Re-licensure

162. We state here our view that the education of a doctor is a continuing process which does not end even at the specialist registration level, but ought to continue to his retirement. Unless a doctor keeps abreast of medical developments it is likely that his competence as a medical practitioner will be seriously affected. There is growing interest in this country in schemes of tying continued registration to periodic tests of competence.

[1]See chapter 5, part B.

163. Although we have been impressed by some of the evidence from abroad which we have seen, we have not felt able to recommend the introduction of any scheme of re-licensure. This is a sufficiently important and complex matter to warrant a separate inquiry of its own. The introduction of re-licensure schemes would represent an enormous change in approach to regulation, and could be recommended only on a firm foundation of evidence. We do not however wish to prejudice the consideration of schemes of re-licensure, especially because the medical profession is in fact mounting its own inquiry in this field. This inquiry is by a Committee which includes representatives of the specialist Royal Colleges and Faculties in England and Scotland, the Royal College of General Practitioners, the British Medical Association, the Councils of Postgraduate Medical Education, and of Community Medicine. The Committee's terms of reference are: "To review the present methods of ensuring the maintenance of standards of continuing competence to practise and of the clinical care of patients, and to make recommendations". The Chairman of the Committee is Mr E A J Alment.

164. We have therefore confined ourselves to passing such evidence relevant to re-licensure as we have received—it is not a great deal—to Mr Alment's Committee. We wish however to express our view here that if at some future time it is decided that a re-licensure scheme ought to be introduced, responsibility for its administration should be placed with the GMC.

165. Despite our unwillingness to recommend schemes making continued registration dependent on continued participation in education, we have no doubt of the importance of continuing education. We wish to make two points. First, the development of provision for continuing education is to be welcomed whenever it occurs. Secondly, although we do not see a precise and definite rôle for the GMC in continuing education such as it will have in the earlier stages of medical education, we believe that using the statutory power we have recommended to promote high standards of medical education, the GMC will be able to encourage and advise on the development of continuing education. The power which we recommend the GMC ought to have to promote research and gather information should be particularly useful in this respect.

Rights of existing doctors

166. We have not considered in detail the effect of the implementation of our recommendations on registration and education on existing doctors and medical students, but we have no doubt about the general principle which ought to be applied. That is that existing status and expectations should not be interfered with. We believe this to be desirable in the interests of getting the radical changes we propose off to a good start. Consequently we believe that, when specialist registration is introduced, every general practitioner who has been in practice as a principal for a number of years—exactly how long would need to be decided after consultation with the profession—should receive specialist registration as a general practitioner. This should only be a once-and-for-all arrangement: there can be no question of making it a regular part of the arrangements; and indeed, as we have pointed out, by 1977 it is hoped that sufficient training programmes will exist for all intending general

practitioners. Similar arrangements to those we have outlined for general practitioners should be made in the hospital field. We think also that our proposals for graduate clinical training should be implemented at a pace which allows medical students to be aware of revised arrangements not too long after they have embarked on their medical studies.

The medical legislation

167. It is not our duty to attempt instructions to Parliamentary Counsel on a Medical Bill to implement our views. Nevertheless, we do wish to make the following points. Part II of the Medical Act 1956 seems to us to be inordinately complicated and old-fashioned legislation on which it would be a mistake to build. We believe that the new legislation should be as flexible as is consistent with the need to ensure that important rights—particularly of the present licensing bodies—are safeguarded. We suggest that the starting point should be the imposition of the duty on the GMC to promote high standards of medical education to which we have referred.[1] The main legislation might provide that the listing of bodies granting primary qualifications (and, if necessary, certificates of experience of completion of graduate clinical training, and accreditation) should be in subordinate legislation. Such subordinate legislation might require the assent of the Privy Council and, it seems to us that if this were done, the present rôle of the Privy Council as an appeal body could be dispensed with. It will be evident that our dislike is concentrated particularly on sections 11–13 of the Medical Act 1956. In any event we do urge very strongly the merits of straightforward and simple legislation.

PART K: CONCLUSIONS AND RECOMMENDATIONS

Our principal conclusions in Chapter 2

(6) Medical registration recognises a certain standard of medical education (paragraphs 25–28 and 31–33).

(7) Because medical registration recognises a certain standard of education, the GMC, as the registration body, must necessarily have power over educational bodies to ensure the equivalence of the standards of education conferring the right to registration (paragraphs 29 and 34–37).

(8) The NHS system of appointing hospital consultants may be regarded as a specialist registration system (paragraphs 44 and 45).

(9) The NHS specialist registration system is weak from a practical standpoint, too flexible as regards standards, and is an obstacle to the co-ordination of the planning of all stages of medical education (paragraphs 54–57).

(10) In considering the control of medical education, a distinction should be made between the control of individuals, the control of standards, and the control of resources (paragraph 63).

(11) The supervision of individuals to ensure that they have reached set standards should reflect the desirability of diversity of educational provision (paragraph 64).

(12) The Postgraduate Councils and the Regional Postgraduate Committees associated with them are an excellent means of resolving problems

[1] In paragraphs 66–70.

involving the interaction of resources and standards; such means of resolution being particularly necessary in the postgraduate field (paragraphs 71–75, 113 and 144–146).

(13) The pre-registration year cannot be regarded as a satisfactory period of education to deal with the important task of making a clinician of the graduate; and its unsatisfactoriness owes much to grave organisational weaknesses apparent in the control of the year (paragraphs 91–99).

(14) The period of general professional training recommended by the Royal Commission on Medical Education does not offer a remedy for the present inadequacy of educational concentration on the task of making a graduate into a clinician (paragraphs 100–104).

(15) There are three recognisable stages of clinical responsibility, namely practice under supervision, independent practice, and practice carrying responsibility for the care of the patient at a high specialist level; and these stages correspond to the three stages of registration we propose (paragraph 124).

(16) The contribution of the Joint Committees on Higher Training and the Postgraduate Training Committee for General Practice to the organisation of specialist medical education is very important (paragraphs 125–129).

(17) The introduction of a specialist register will, in the long run, secure, through its recognitionary character, that a specialist education will be normally necessary for any doctor wishing to exercise the highest degree of clinical responsibility (paragraphs 156–159).

Our principal recommendations in Chapter 2

(1) A specialist education should be, in general, a pre-condition of the independent practice of medicine (paragraphs 48 and 52).

(2) The planning of all stages of medical education should be co-ordinated (paragraphs 58–62, 70, and 120–121).

(3) The medical legislation should be amended to impose a duty on the GMC to promote high standards of medical education (paragraphs 66–70).

(4) Successful completion of an undergraduate course in medicine should confer the right to "restricted registration" (paragraphs 78 and 79).

(5) The GMC should continue to have the power to refuse to accept that a primary qualification is adequate for the purposes of registration; and should continue to have powers to visit and inspect medical examinations and to visit medical schools (paragraphs 80 and 81).

(6) The GMC should develop further its informal methods of controlling undergraduate medical education, particularly by involving external examiners (paragraphs 82–84).

(7) The GMC and the University Grants Committee should develop machinery to exchange information (paragraphs 85–87).

(8) The important task of making a clinician of a graduate requires the introduction of what we refer to as "graduate clinical training" (paragraphs 88–90).

(9) Control of the standards of individuals undergoing graduate clinical training should rest with university medical schools (paragraphs 108–111).

(10) The universities will require more tutorial resources to discharge the responsibility we propose for them in relation to graduate clinical training (paragraph 112).

(11) Overall control of the standards of graduate clinical training should rest with the GMC and in particular, the GMC should be empowered to refuse to accept medical schools' certificates of completion of graduate clinical training (paragraphs 114 and 115).

(12) The GMC should be provided with reserve inspectorial powers in relation to graduate clinical training (paragraph 115).

(13) The GMC should develop informal methods of controlling graduate clinical training (paragraph 116).

(14) The length of graduate clinical training should be a matter for specification in regulations made by the GMC after wide consultation (paragraphs 117–119).

(15) Successful completion of graduate clinical training should confer the right to "general registration" (paragraph 122).

(16) General, or family, practice should be recognised as a specialty just like other areas of medical practice (paragraph 129).

(17) Control of the standards of specialist education should rest with the GMC by its maintenance of a specialist register (paragraphs 130 and 131).

(18) The re-organisation of specialist medical education should be founded on the work of the Royal Colleges and Joint Committees on Higher Training (paragraph 133).

(19) Control of the standards of individuals undergoing specialist education should rest in the hands of any body given that responsibility by the GMC (paragraph 133).

(20) Detailed arrangements for the control of standards of specialist education by the GMC should be worked out in the give and take of wide consultation (paragraph 135).

(21) An inescapable consequence of the introduction of specialist registration is that the GMC, as the registration body, should have the power to determine whether any body's accreditation should confer the right to specialist registration (paragraphs 136 and 137).

(22) The GMC should be empowered to send for those papers of accrediting bodies relevant to accreditation as a specialist (paragraph 138).

(23) The GMC should develop informal methods of controlling specialist education, for example, in the fields of the interchangeability of specialist experience, the relative complexity of specialties, the assessment of individuals and the efficient use of the skills of women doctors through part-time specialist training (paragraphs 140–142).

(24) The possibility of an appeal right to the GMC from the decision of an accrediting body, particularly on questions of the relevance of experience, should be considered (paragraph 139).

(25) A specialist register should be instituted (paragraphs 147 and 148).

(26) The specialist register should be indicative in character (paragraphs 149–155).

(27) The status of specialist registration should be protected by the GMC (paragraphs 160 and 161).

(28) Continued registration should not depend on continued participation in education, but the GMC should encourage the development of continued participation in education (paragraphs 162–165).

(29) The status and expectations of existing doctors should be taken very fully into account (paragraph 166).

(30) Simplification of that part of the medical legislation dealing with education is highly desirable (paragraph 167).

CHAPTER 3 : OVERSEAS DOCTORS

PREAMBLE

In examining the problems of registering overseas doctors, it is important to bear in mind that among the graduates of any medical school abroad or in the United Kingdom, there will be found a range of competence. It is the GMC's prime duty to ensure that no doctor is placed upon the register who falls below some minimum standard. For doctors trained in the United Kingdom the GMC defines this minimum standard as the standard required to pass the examinations of the candidate's medical school, whose standards will be well-known to the GMC. It seems to us that the only possible posture for the GMC to adopt for the registration of overseas graduates is that it must ensure that the overseas doctor has reached a standard of competence which is at least equivalent to that of the minimum standard required for the registration of a doctor trained in the United Kingdom. Anything else is a disservice to overseas doctors themselves whose contribution to the working of the NHS is immense. How it ensures the competence of overseas doctors will be a matter for the GMC to decide, and after it has done so it will have placed upon the register, just as it does with United Kingdom graduates, overseas doctors with a range of skilfulness. But in both cases the GMC has guaranteed to the patient a minimum standard of skill and care. This chapter is concerned with the special arrangements which are necessary in order to ensure this.

PART A: THE NATURE AND SCALE OF THE PROBLEM

168. We have said in chapter 2 that the purpose of registration is to recognise the achievement of a certain educational standard: that is, to identify persons who have received an education which fits them to practise as doctors. This is as much the case for doctors with qualifications gained overseas as it is for those who have been educated in this country. It is therefore important that the arrangements for registering overseas doctors ensure competence to practise as adequately as do the arrangements for the registration of doctors trained in the British Isles. It is no exaggeration to say that the present level of care offered by the NHS itself would have collapsed long ago without the crucial contribution of overseas doctors. Nonetheless, a good deal of evidence was offered to us which suggested that the present arrangements for their registration were less than perfect and we felt it essential to examine this evidence carefully. This is obviously a matter of concern to the public who may be treated by overseas doctors, to members of the medical profession whose successful practice will often depend on colleagues' competence, and to overseas practitioners themselves whose effectiveness as doctors may be reduced by doubts about the value of their qualifications.

169. The importance of the topic is best demonstrated by quoting the following evidence from the Health Departments.

> "There are about 13,300 overseas born doctors in the National Health Service in Great Britain. Most of these (and a few British-born) qualified overseas. Some are permanently established here in career posts; broadly, these are the 3,450 general practitioners and 1,900 doctors in hospital

career grades (about 14% of each group). Other young doctors are spending limited periods here before returning home or going to other countries overseas. They are mainly in the hospital training grades (8,000, comprising 42% of the total in the grades). Some of those who come in the first place to hospital training posts eventually settle in career posts.

The staffing of the National Health Service requires annual increases in the numbers of doctors. The Todd Royal Commission, in estimating the required rate of increase, used a formula (related partly to population growth) which worked out at about 2% a year, or about 1,400 extra doctors a year in Great Britain. This has been reached or exceeded in recent years. Only a proportion—up to the present, less than half—of this increase comes from the output of British medical schools. (The actual number varies considerably from year to year, because it depends not only on the numbers of new graduates which are fairly predictable, but also on the less predictable number of British doctors leaving the country and returning to it year by year, and on numbers moving into and out of NHS employment within the country). Up to the present, maintenance of development of the Service has taken up an annual net addition to the numbers of overseas doctors here of 700 a year or more. Allowing for the fact that many overseas doctors leave each year—in the region of 2,000—*maintenance of development of the National Health Service at present involves the admission of a total of between* 2,500 *and* 3,000 *overseas born doctors a year*[1] [our italics].

As the programme of expansion of British medical schools goes forward we shall no longer be so excessively dependent on overseas doctors, and the annual net gain needed should diminish through the 1970s; but even then considerable numbers will leave, and others will come, each year".

170. These comments were sent to us in early 1974 and, as the evidence envisages, the reliance on overseas doctors may be diminishing. The present contribution of overseas doctors was set out in the report of the Chief Medical Officer for 1973.

"On 1 October 1973, 3,509 (16·5%) of unrestricted principals in practice in England and Wales were born outside the United Kingdom or Eire, an increase of 194 (1%) over the previous year. In the hospital service, 9,745 (34·7%) of the 28,074 doctors in grades other than clinical assistants were born outside these countries, an increase of 725 over 1972. The numbers and percentages in the hospital grades are as follows:—consultants 1,421 (13·2%), medical assistants 367 (38·9%), senior registrars 522 (25·4%), registrars 2,711 (55·9%), SHOs 4,071 (60·9%) and pre-registration house officers 422 (20·6%). Each grade shows a proportionate as well as a numerical increase over figures for 1972. Some of these doctors may have been born abroad of British parents, and others may have graduated from British Medical schools and lived in this country for a number of years".

Overseas doctors do of course tend to be concentrated particularly in certain areas.

[1]As a comparison, the output of the UK medical schools in 1973 was 2,289.

171. In considering the arrangements for the admission of overseas doctors we found it helpful to keep two questions in mind. The first is the extent to which the GMC should depart from the means which it uses of assuring itself of the quality of doctors in this country—namely, acceptance of the assessment of the candidate's medical school—and operate assessment of individuals' competence. Clearly the GMC has not, and can never have, the same intimate knowledge of overseas medical schools as it has of the medical schools of this country. It necessarily follows that a greater burden will be thrown on the GMC's judgment of the competence of individuals. The second is how relevant to the consideration of schemes of control is the doctor's country of origin, bearing in mind such developments as the replacement of an Empire by a Commonwealth and this country's membership of the European Economic Community.

PART B: THE PRESENT ARRANGEMENTS

The registration of overseas doctors

172. For any doctor who has qualified in an overseas country to be granted *full registration* the following conditions must be satisfied:

(*a*) Part III of the Medical Act 1956 has to be applied to the overseas country by Order in Council.[1] The real significance of this is that it involves the Government in the granting of full registration to overseas doctors.

(*b*) The GMC has to recognise, under section 20 of the Medical Act 1956, the qualification which the doctor possesses as furnishing a sufficient guarantee of the requisite knowledge and skill for the efficient practice of medicine, surgery, and midwifery. This is of course the same test as for primary qualifications acquired in the British Isles.

(*c*) The individual has to have had certain practical experience: "not less extensive" than the pre-registration year for doctors trained in the British Isles.

A doctor who satisfies the first two conditions above would be allowed *provisional registration*; that is, he could work only as a resident house officer. Full and provisional registration for overseas doctors have exactly the same significance as they have for practitioners who qualified in this country. Quite separate from the above is *temporary registration*. This is available to a doctor with any overseas qualification which the GMC is prepared to recognise. It allows the doctor to work in a specified capacity in a hospital approved by the GMC for temporary registration. Any temporary registration applies only to a particular appointment, but the appointment can be at any level in the hospital hierarchy so that it would theoretically be possible to make a career in the NHS hospital service without obtaining more than temporary registration.

173. The difference between the provisions for recognising overseas qualifications for the purpose of full registration and those for the purpose of

[1]This is explained further in paragraph 175.

temporary registration is important. Under the current provisions, a doctor who has obtained an overseas qualification which the GMC has recognised for the purpose of full registration and who satisfies certain other conditions as to professional experience and character is, statutorily, "entitled to be registered . . . as a fully registered practitioner" without further examination in this country. The terms of the legislation do not permit the GMC to subject such doctors to tests, whether of clinical competence or of linguistic capacity. By contrast, the GMC has considerable discretion in granting temporary registration.

174. It is possible for doctors trained overseas whose qualifications allow them to be only temporarily registered to obtain full registration without attending a medical school in the British Isles by obtaining the diploma of the Royal College of Surgeons and the Royal College of Physicians; the licentiate of the Society of Apothecaries of London; or the joint qualification of the Scottish Royal Colleges. Since 1968, although exceptions are made, the general rule has been that only overseas doctors with a qualification which is recognised for temporary registration, and who have completed 12 months' service in a United Kingdom hospital, are allowed to sit for these qualifications.

The establishment of reciprocal relations

175. We have explained that a condition of doctors from an overseas country being able to obtain full registration in this country, other than by obtaining a primary qualification from an educational body in the British Isles, is that Part III of the Medical Act 1956 has been applied to their country. Section 19 of the Act provides that such an Order may be made "If Her Majesty is of opinion that any part of the Commonwealth outside the United Kingdom, or any foreign country, affords, [to British doctors] such privileges of practising there as to Her Majesty may seem just . . .". In other words this is a provision for establishing reciprocal privileges of practice. The practical effectiveness of an Order is dependent upon the GMC's willingness to recognise, under sections 18 and 20 of the Medical Act 1956, the qualification which the doctor possesses. It has therefore been the practice of the Government not to make an Order before it has been ascertained that the GMC is prepared to recognise qualifications granted in the country concerned.

Recognition of qualifications for full and provisional registration

176. The GMC, at present, recognises for full or provisional registration, primary medical qualifications granted by 86 medical schools overseas. Before 1920, only a few overseas universities were recognised, and recognition was extended on the basis of documentary information received from the institutions concerned. During the 1920s the GMC found it useful to institute a system of visitation, particularly of universities and medical colleges in India, and the system was later extended to other countries. Of the 86 overseas medical schools currently recognised, 43 have been visited by the GMC at least once during the last 20 years, though these visits have varied in formality and scope. Those visits which were made with a view to the recognition of qualifications of a new medical school were usually conducted by a team of three visitors who spent several days in the school, and submitted a detailed report of their

findings. Others were more informal. Many medical schools which are recognised have not, however, been visited in this way. These are mainly situated in India, Canada and South Africa, where there are statutory Medical Councils with the duty of maintaining standards of medical education. Recognition has been extended to a number of medical colleges after reports of inspectors appointed by the national Medical Council have been forwarded to the GMC, and duly considered.

Recognition of qualifications for temporary registration

177. The granting of temporary registration does not depend on the existence of reciprocal relations, and is much less regulated by statute than is the granting of full registration. The GMC at present recognises, for temporary registration, primary medical qualifications granted in more than 70 countries. Recognition is extended after consideration by the GMC of documentary information about the institutions and curricula concerned. The GMC told us that it is difficult to do more than to establish that on paper the curriculum covers approximately the same subjects and is of approximately similar duration to the curriculum in this country. The GMC has pointed out also that the relative freedom from restrictive legislative conditions which characterises temporary registration has two consequences. First, the GMC has felt able to take a more liberal approach to the recognition of overseas qualifications for the purpose of temporary registration than to their recognition for the purpose of full registration, because temporary registration entitles the doctor to work only in a specified post in an approved hospital. Where a doctor's qualification is from a medical school about whose standards some uncertainty exists, the GMC has, in the first instance, restricted the doctor to work in a pre-registration post, and has sought reports upon his work before agreeing to grant further periods of temporary registration. Secondly, the GMC has been able to take into account such matters as the doctor's linguistic ability, relevant professional experience, character, mental health, and clinical competence, when deciding whether to grant or renew registration.

The Clinical Attachment Scheme of the NHS

178. The broad purpose of the NHS Clinical Attachment Scheme was stated by the Health Departments in evidence to us as being "to help overseas doctors to obtain the experience they seek and to help NHS hospital authorities to see that doctors were suitable for employment, having regard to their linguistic and clinical competence". The period of the attachment is ordinarily one month. The scheme applies to all overseas doctors, whether eligible for full, provisional, or temporary registration: indeed, hospital authorities may not employ an overseas doctor unless he has successfully completed a clinical attachment or has been exempted. So far as regulation is concerned, clinical attachment is of most significance in relation to temporary registration, since the GMC takes into account reports from NHS consultants when renewing temporary registration.

PART C: THE STANDARDS OF OVERSEAS DOCTORS

179. In this part we set down certain evidence on the standard of overseas doctors practising in this country.

The problem of assessing standards

180. In the summary which follows of the evidence we have received concerning the competence of overseas-educated doctors, it is important to bear in mind that among the graduates of any medical school, wherever in the world it may be, there will be found a range of competence. It is important to be mindful, too, of the difficulty of collecting evidence of this kind and judging human capacities.

The objective evidence

181. The most convincing evidence we received of a different and lower standard of doctors from certain overseas countries from that of home-trained doctors concerned the performance of candidates attempting the examinations of two Royal Colleges. First were the results of doctors taking the first three examinations of the Royal College of Psychiatrists. The number of candidates to which this study applied was 1,031, more than 300 taking each examination. 68% of the candidates came from the United Kingdom, Australasia, or South Africa. 26% of the candidates came from the United Arab Republic or from the Indian sub-continent. The following table compares the pass rate of these two groups.

	Examinations (per cent)			
	I	*II*	*III*	*All*
UK, Australasia, South Africa	80	84	79	81
UAR, Indian Sub-Continent	47	44	48	47

The discrepancy in the pass rate of the two groups is very marked, the second group having an overall pass rate 34% less than the first group. These figures are given additional significance by tables published by the Department of Health and Social Security for 1972 which show that 60% of registrars, 34% of senior registrars, and 16% of consultants engaged in mental illness were born outside the United Kingdom or the Irish Republic.[1]

182. In addition, we received the following evidence from the Royal College of General Practitioners.

"In three recent examinations, whose candidates were obviously drawn only from a group of practitioners who wanted to become members and were therefore prepared to be assessed, 188 out of 289 doctors passed, a 65% overall pass. Certain trends emerged:—

(*a*) for young doctors who had completed three-year vocational training programmes for general practice (44) the pass rate averaged over the three examinations was 89%.

(*b*) for established principals who received their undergraduate training in the United Kingdom (196) the averaged pass rate was 75%.

(*c*) for graduates of universities overseas (49, but none from Eire) nearly all of them now principals in the National Health Service, the averaged pass rate was 6%".

[1]The Department's figures will naturally include some of those in the upper line.

Although, as the College pointed out, the numbers involved are small and so must be interpreted with caution, we agree with their conclusion that the fact that only 3 of the 49 doctors who received their education overseas passed the College's examination, is a disturbing indication of the quality of such doctors entering general practice. The College later sent us consolidated figures for their membership examinations from spring 1972 to autumn 1974. These figures related to 1,010 candidacies. The overall pass rate for 869 doctors who came from the United Kingdom and the Republic of Ireland was 82%. The pass rate for the other 141[1] was 21%.

183. We also noted material published in the "British Medical Journal" during the course of our work.[2] This provides an abridged table of results of the 1972 examination of the Educational Council for Foreign Medical Graduates, an American body. The Council's examination takes account of the doctor's educational background, and aims to test both medical knowledge and command of English. The successful candidate is provided with a certificate to the effect that he has reached the minimum standard expected of graduates of an American medical school. The examination is used as a screening process by many State Boards, who then normally require the doctor to satisfy their own licensing requirements before he is allowed to practise independently. The examination does not, therefore, relate directly to overseas doctors in the United Kingdom, nor to the educational requirements of this country. It does, however, provide some comparison of the relative performance of doctors from a number of countries including the United Kingdom, in a test of medical competence conducted in English.

Abridged Table of Results of ECFMG Examination (1972)

Country	No. Sitting	Proportion who Passed	
		No.	%
Malaya (Kuala Lumpur)	86	86	100
Rhodesia	11	11	100
Australia	685	664	97
United Kingdom	447	420	94
New Zealand	78	72	92
Hong Kong	125	111	89
Scotland	207	185	89
Singapore	101	89	88
South Africa	374	330	88
West Indies	70	60	86
Uganda	69	59	85
Northern Ireland	50	41	82
Sri Lanka	48	36	75
Eire	358	266	74
India	4,078	1,667	41
Burma	168	62	37
Pakistan	972	245	25
U.S.S.R.	120	12	10

[1]93 from India, 15 from Pakistan, seven from Sri Lanka, five from Burma, five from South Africa, three from Singapore, two each from Bangladesh, Greece, Kashmir and the West Indies, and one each from Egypt, Malta, New Zealand, Nigeria and Norway.

[2]Article by Dr. Myre Sim: British Medical Journal, Supplement 1973, 4, 65–68.

The subjective evidence

184. We could not fail to be aware of a widespread conviction that the standard of overseas-educated doctors allowed to practise in this country is lower than that of home-educated doctors. Expressions of this belief can be found regularly in the correspondence columns of the medical journals. Such feeling was evidently the cause of the review which the GMC has been conducting into the registration of overseas doctors. The evidence of the British Medical Association to us, with its suggestion of limiting the entry of overseas doctors by imposing a test akin to the United Kingdom undergraduate examination, obviously represents disquiet with the present standards of overseas doctors. The Committee of Vice-Chancellors recommended us to take account of "the widespread belief that present conditions of registration of foreign doctors are unsatisfactory". In oral evidence to us, representatives of the Government expressed concern about the standard of overseas doctors. Further examples of subjective evidence could be quoted, but we believe it more valuable to give specific examples of problems which we believe have led to the general concern we have mentioned. The most illuminating summary of difficulties experienced in contacts with overseas doctors came from the Royal College of Nursing whose evidence contained the following comments:

> "Reference was made by several members to the danger of medical instructions, given either in writing or verbally, being misinterpreted by nurses when the use of English is poor. The use of the telephone to relay messages also presents a problem when there is a language difficulty and evidence of the wrong diagnosis being given, as well as misunderstanding about both the admission and discharge of patients, has been referred to. . . Misunderstandings readily occur between the patient and the doctor when the doctor does not speak English competently; explaining the nature of an operation, discussing the patient's condition and interviewing relatives, present particular problems. Doctors who do not speak English well present the particular difficulty in psychiatric hospitals where the face to face interview between the doctor and the patient is an essential part of diagnostic and treatment procedure. An example was given of the doctor from abroad who interpreted the use of colloquialisms by the patient as a sign of confusion and disorientation. . . The ethical principles and cultural background peculiar to the United Kingdom give rise to a great deal of difficulty for doctors from certain countries where values and principles are different. . . It is the view of the RCN that overseas doctors are given very little introduction into hospital life, its management, policies and procedures".

In our view these comments, which were echoed in much other evidence, have the ring of conviction.

Our conclusions on the evidence

(*a*) *What it shows*

185. We believe that the inescapable conclusion to be drawn from the evidence we have received is that there are substantial numbers of overseas doctors whose skill and the care they offer to patients fall below that generally acceptable in this country, and it is at least possible that there are some who should not have been registered. Although these remarks must be read in the light of what we

have said in the preamble to this chapter and in paragraph 180 about the range of competence, we nevertheless believe that an overseas doctor may be allowed to practise in this country with a knowledge of medicine less than the minimum that would be required of his counterpart educated in the British Isles.

186. Apart from this generally lower level of professional knowledge and skill, the evidence shows a second, although sometimes overlapping, difficulty. Much of the evidence reflects not upon the overseas doctor's professional knowledge and skill but on his understanding of patients and grasp of the language, attitudes, values and conventions of the community in which he practises. Even where an overseas doctor is fully knowledgeable and articulate in the professional field, his difficulty in communicating with patients in non-medical terms may constitute a major barrier to his integration into medical practice in this country. It would be surprising if doctors from overseas did not lack knowledge of the operation of the NHS, did not find difficulty in understanding the significance of the euphemisms and colloquialisms which for many patients are their most accurate means of expression, and even more surprising if they could easily come to grips with the variety of dialects they may encounter. This will particularly be the case where the graduate comes from a country where English is not spoken or where the use of English as a teaching language is being discontinued.

(*b*) *Our view of the causes of the unsatisfactory situation*

187. We believe that this unsatisfactory situation is principally to be attributed to a willingness on the part of the GMC to allow its duty as the protector of medical standards to be compromised by the manpower requirements of the NHS. The following evidence from the GMC is relevant:

> "Indirectly the decisions of the Council in this area have, at least in recent years, been to some extent influenced by medical manpower requirements. In the first place the medical manpower needs of the National Health Service have caused the rapid growth in the volume of applications for full, provisional and temporary registration by overseas doctors which has occurred during the last 20 years. In granting temporary registration, therefore, where the doctor has to be selected for employment before he can apply, the Council has been responding to the manpower needs of the Health Service. Secondly in approaching the question of the possible withdrawal of recognition from qualifications previously recognised, the Council has been aware that any precipitate action might embarrass the National Health Service; and that this factor might influence the Privy Council in deciding any appeal against a refusal by the Council to recognise or to continue to recognise a qualification".

The Health Departments made no bones about their views: "The arrangements for the admission of overseas doctors must neither impede nor deter those whose medical education and ability are of an appropriate standard and character for work in the NHS". It will be recognised that this differs little, if at all, from an assertion that the NHS should set its own standards.

188. A further difficulty contributing to the present unsatisfactory state of affairs is that the admission of overseas-educated doctors is governed by legislation, the central provisions of which have remained substantially

unchanged since 1886. In particular the legislation seems to us to reflect an inappropriate sharing of responsibility between the Government and the GMC for the admission of overseas doctors.[1]

PART D: OUR GENERAL VIEW

Standards of doctors a matter for the GMC

189. We recommend that the GMC register only those overseas-educated doctors whose standard is up to the minimum required of a medical graduate in this country.

190. We have pointed out that the Health Departments' evidence differs little, if at all, from an assertion that the NHS should set its own standards for overseas doctors. We understand that lying behind the Health Departments' argument is the view that this is a practical position to take up: it allows for the possibility that in the United Kingdom the educational standards are, and should be, as high as, or higher than anywhere in the world, but that, provided an overseas doctor is competent, at a reasonable and appropriate standard for a junior hospital post, he should be allowed in by the GMC, even though it may be uncertain whether his country's educational standards are as high as ours. To insist, the argument continues, in the foreseeable future, on a United Kingdom standard, would require the expansion of medical schools in this country much faster than planned, and to an eventual size larger than planned. Such an argument is in our view unsound. It must carry the corollary that doctors in the British Isles are trained to an unnecessarily high standard. As a Committee we do not accept that doctors in the British Isles are trained to an unnecessarily high standard—and we doubt whether the assertion of the contrary by the Health Department would be accepted to be a disinterested comment. It is not for us to judge the ethics of a service which relies on a substantial supply of doctors from countries which are themselves seriously short of medical services.

191. It is in any event plain where lies the general risk of allowing the providers of services to set standards: it lies in the dilution of standards and more particularly the modification of standards to meet the needs of the moment.

192. We have criticized the GMC for what we believe to have been undue complaisance in the face of NHS manpower needs. The GMC has, however, brought forward comprehensive proposals for change which seem to us generally satisfactory. Indeed we largely endorse the GMC proposals—*so long as they are operated resolutely and with a determination to make good the general aim which we have declared.*

The desirability of an examination at primary qualification level

193. The British Medical Association suggested to us that "there should not be any automatic recognition of primary medical qualifications gained overseas". The Association proposed that "all doctors from overseas (unless future EEC directives dictate otherwise) who wish to practise in the United

[1]See paragraph 205.

Kingdom should be required to pass a written and clinical examination of the same standard as a United Kingdom qualifying examination before admission to any form of medical registration". We believe that the Association's suggestion goes too far by ignoring the value of some overseas qualification—many of which may represent as high a standard as the comparable British Isles qualification. Furthermore, we deplore the prospect that such an examination might act as a sort of international tariff barrier cutting off the United Kingdom from the international community of medicine.

194. This is not to say that we are against all testing of overseas doctors, and indeed we support the GMC's proposals for tests for doctors wishing to be temporarily registered; tests which, as we point out,[1] will form the model for more permanent arrangements. The Educational Council for Foreign Medical Graduates (ECFMG) examination in the United States of America has obvious relevance to such tests, and the GMC will no doubt take into account any lessons to be learned from this examination.

The contribution of overseas doctors

195. Both in the collection of evidence and in the preparation of this report we have had to concern ourselves with deficiencies in the standard of some overseas doctors and some overseas qualifications. We have to record also —and we do so with pleasure—the large volume of opinion testifying to the immense contribution which overseas doctors have made to the NHS. It would ill become us as a Committee if our recommendations for change were not coupled with an endorsement of the gratitude which many of our witnesses have expressed to us. Indeed we believe an important consequence flows from this. Great sensitivity will need to be shown in explaining why arrangements can no longer be made to recognise the qualifications of some countries while continuing to recognise those of others, particularly when the second category is being enlarged by our entry into the European Economic Community. It would also of course be unacceptable for any changes to result in the withdrawal of presently held rights to practise.

PART E: THE GMC'S PROPOSALS

196. In May 1971 the GMC appointed a Special Committee to review the present arrangements for registration in this country of doctors qualifying overseas. Three main developments ensued. *First*, the GMC initiated a review of those qualifications it recognises for the purposes of full registration. *Secondly*, the GMC made proposals for change requiring legislation. *Thirdly*, the GMC made proposals for change not requiring legislation. We set down these two sets of proposals in the next two sections.

GMC proposals for change requiring legislation

197. The GMC's proposals for a new system for controlling the right to practise of overseas doctors are as follows.

> "40. The Council proposes that, if the necessary legislation can be obtained the present arrangements for registration of overseas doctors should be modified in a number of ways . . .

[1]See paragraph 201.

I. *Full registration*

41. Full registration would in future be available for overseas doctors falling within the following categories:—

(i) Doctors holding an overseas primary qualification which the Council had recognised as of a sufficient standard to justify the granting of full registration (provided that the doctor had also completed a house officer year). The circumstances in which the Council might in future recognise overseas qualifications for this purpose are discussed more fully in paragraphs 42–44 below.

(ii) Doctors who obtain by formal examination qualifications such as the MRCS; LRCP; LMSSA; and the Scottish Triple. It is suggested in paragraph 46 below that the examinations held for these qualifications might be relaxed in certain respects in favour of certain overseas doctors.

(iii) Doctors who have held limited registration and become eligible for full registration under the procedure described in paragraphs 52–54 below.

As indicated in paragraph 45, doctors in categories (i) and (ii) would need to produce evidence of house officer experience in addition to evidence of qualifications.

42. The Council would recognise an overseas qualification for full registration if, but only if, the Council was able to satisfy itself, and to remain satisfied, by inspection or other appropriate means, that the standard of such qualifications is not less than the minimum standard required for primary qualifications granted in the United Kingdom . . . The number of overseas qualifications which would be and remain capable of recognition by this criterion would be likely to be considerably less than the number at present recognised. It would also be necessary for the Council to be satisfied that any overseas qualifications recognised for this purpose complied with any relevant directives of the EEC: it is, however, unlikely that this would in practice prevent the Council from recognising any qualification which the Council was, on other grounds, disposed to recognise.

* * * * *

45. Doctors who hold qualifications recognised for full registration would . . . need to satisfy the Council (as at present) that they have had professional experience equivalent to that required for full registration in the case of doctors qualified in the United Kingdom. If doctors holding overseas qualifications recognised for full registration arrive in this country not having had such experience, they would be able to apply for limited registration until they had acquired the necessary experience.

46. Overseas doctors should be able to obtain full registration by taking the examinations held by one of the Conjoint Boards or the Society of Apothecaries for registrable primary qualifications. Modifications in the present structure of these examinations might be permitted in favour of certain overseas doctors. [There is] a suggestion by the English

Conjoint Board that the final examination for the MRCS LRCP should be modified so as to permit exemption from the examinations in Medicine or in Surgery for candidates who have obtained the MRCP or FRCS respectively. Provided that the conditions of exemption were properly drawn [there is] no objection to these suggestions, although legislation would be required to implement them fully. If the suggestions were adopted they would be likely to increase the attraction of these examinations for a proportion of overseas doctors.

II. *Limited registration*

47. A new category of limited registration should be instituted to supersede the present system of temporary registration (and also provisional registration so far as this is at present available for overseas doctors).

48. Such registration should be limited in two ways, namely:—

(*a*) The Council would have discretion as to the *period* for which limited registration should be granted on any occasion (though no condition as to temporary residence in this country would be attached).

(*b*) The *range* of employment for which registration would be granted on any occasion to any particular doctor could be limited to:

(i) Employment in one specified hospital as under the present system or temporary registration;

(ii) Employment in recognised pre-registration posts;

(iii) Employment in the hospital service in certain specified grades;

(iv) Employment in the hospital service in a specified branch of medicine;

(v) Employment in an approved training post in general practice;

(vi) Employment in the Community Health Services or in specified grades or posts in those Services.

49. It should be open to the Council, at its discretion, to grant limited registration, or successive periods of limited registration, indefinitely to any doctor so that it would be possible for an individual to make a permanent career on the basis of limited registration.

50. Limited registration would be granted at the Council's discretion to doctors who satisfied two conditions:—

(i) The doctor must hold an overseas qualification recognised by the Council for the purpose of limited registration. It is envisaged that qualifications would be recognised for this purpose on the same basis as that now used for temporary registration, that is to say recognition would be extended, usually on the basis of documentary information, to any qualification which appeared to be granted after a curriculum broadly equivalent in length and scope to the undergraduate medical curriculum in this country.

(ii) The doctor must also have successfully passed a test or systematic assessment of his ability to communicate in the English language and of his ability to apply in the treatment of patients in this country the knowledge and skill which he had acquired in his basic medical education. It is envisaged that these tests might be conducted by the Examining Board in England (English Conjoint Board), the Board of Management of the Scottish Triple Qualification, and the Society of Apothecaries of London. Doctors who had obtained a specified additional qualification (eg MRCP, FRCS) or who had passed the ECFMG at a specified level might be exempted from these tests.

51. Depending upon the nature and results of the tests or assessments applied before limited registration was granted, it might or might not be necessary for the Council to use its discretion to limit the work in which a doctor was permitted to engage, both in terms of relative responsibility (eg. grade) and of branch of practice, according to the qualifications and the attested experience and competence of the individual doctors.

III. *Progress from limited registration to full registration*

52. In the case of those doctors holding qualifications recognised for full registration who had not before arriving in this country completed their house officer year, progress from limited registration to full registration would, as at present, depend simply upon the doctor satisfying the Council that he had held the requisite pre-registration posts. The following paragraphs discuss the position of doctors granted limited registration whose original qualifications are not recognised for the purpose of full registration.

53. As already indicated it should be possible for a doctor who wishes to make a permanent career in this country to do so in a restricted field of practice on the basis of limited registration. Some doctors, however, who (*a*) are not by their qualification eligible for full registration, and (*b*) have worked satisfactorily for some years in this country on the basis of limited registration, and (*c*) are not prepared, because of age or other factors, to submit to a formal examination for a primary qualification, will wish to achieve full registration.

54. A flexible procedure should be devised and made available for this purpose. The object of this procedure would be to enable the Council to be satisfied that the doctor had attained a standard of professional knowledge, skill and experience which would justify the granting of full registration. In order to satisfy itself on these matters, the Council would need to take into account (1) the standard of the doctor's qualifications, both primary and additional, and (2) the range and nature of his professional experience, either overseas or (more usually) in this country. For the latter purpose the Council would need to be able to take into account reports of his work under supervision in this country held on the basis of limited registration. In order that the Council might be satisfied that the doctor was adequately trained in both medicine and surgery, it might be necessary to require him to hold approved hospital appointments

in both these disciplines or appropriate branches of them, but if he held a higher qualification in Medicine or Surgery he might be exempted from holding a further appointment in that discipline. It would also be necessary to obtain adequate confidential reports on the doctor's abilities by the consultants or other doctors under whom he has worked."

In short, these proposals involve restricting the right to full registration; replacing temporary registration by a new system enabling a closer scrutiny of individuals; and provide a means for doctors with the registration replacing temporary registration to proceed to full registration.

GMC proposals for change not requiring legislation

198. This section outlines the GMC's proposals for the revision of its procedures for granting temporary registration. The GMC is proposing to introduce a more structured system of assessment which it hopes to put in operation in 1975. The system of assessment proposed is two part: an examination and a period of clinical attachment.

199. The examination would be set, in the United Kingdom, by a board, the Temporary Registration Assessment Board, drawn from the non-university examining bodies.[1] The Board would test both professional and linguistic capacity. Professional knowledge and ability to understand written English and to write English would be tested by papers. A short viva voce examination would provide an additional test of professional knowledge as well as a test of the ability to communicate verbally in English. Grading in the test would be done by panels of assessors. The assessors would report their findings and recommendations to the GMC which would remain responsible for granting or refusing temporary registration after receiving their report. The GMC would be responsible for the financial arrangements for the examination but expects to recover the expenses involved from the candidates. The GMC would also conduct the correspondence with individual applicants.

200. This test would be linked with improved arrangements for clinical attachment through the NHS. The GMC has discussed the Clinical Attachment Scheme with the Department of Health and Social Security and has made the following proposals. *First*, the present scheme should be expanded very considerably. Until this position is reached the GMC should be given control of the granting of exemptions. *Secondly*, the length of the attachment, which is in any event to last not less than two weeks, uninterrupted by absence on account of going for interviews for jobs, should last sufficiently long for an assessment to be made. *Thirdly*, assessment should be by consultants appointed on the advice of Regional Postgraduate Deans. The consultants should give their assessment on a questionnaire designed to elicit a more comprehensive assessment than before; the GMC would pay a fee for this assessment. *Fourthly*, so far as practicable some instruction should be provided during the period of attachment to enable candidates to adapt themselves to the British hospital system.

[1]That is, the Conjoint Board in England, the Society of Apothecaries of London, and the Board of Management of the Scottish Triple Qualification.

The relevance of the GMC's temporary registration proposals to its legislative proposals

201. It is important to recognise that the GMC's proposals on temporary registration, which we have described in paragraphs 198–200 would no doubt form a model for the GMC's new procedures for limited registration: namely the tests referred to in paragraph 50(ii) of the GMC's memorandum quoted earlier.

Our commentary on the GMC's proposals

(*a*) *The review of the qualifications recognised for full registration*

202. This review has been under way whilst we have been working. We commend to the GMC, in carrying out the review, a resolute observance of its own dictum, suggested in the memorandum we have quoted: "The Council would recognise an overseas qualification for full registration if, but only if, the Council was able to satisfy itself, and to remain satisfied, by inspection or other appropriate means, that the standard of such qualifications is not less than the minimum standard required for primary qualifications granted in the United Kingdom".

(*b*) *The GMC proposals for change requiring legislation*

203. We believe the GMC's proposals for change requiring legislation to be fair and sensible. We think it correct that permanent arrangements should reflect a reduction in the conferment of a right to full registration.[1] We welcome the emphasis on flexibility of the proposals, and the provision for closer assessment of the standards of overseas doctors.

204. The *first* specific point which we wish to make on the GMC proposals relates to the immediate granting of full registration to certain distinguished doctors referred to in paragraph 53(*c*) of the GMC evidence. We support this proposal provided the GMC shows great discretion in the matter. In particular we commend the following evidence from the British Medical Association. The Association referred to excepting (from the examination they proposed) "overseas doctors of high repute and distinction who are recommended by a Royal College or Specialist Faculty or Specialist Association in the United Kingdom, including doctors involved in 'exchange' visits to the United Kingdom arranged by those Colleges, Faculties, or Associations". We believe such recommendations will provide an important safeguard.

205. We wish to comment, *secondly*, on the proposed discontinuation of the present system of reciprocity.[2] We recommend that the existence of reciprocal privileges of practice should cease to be a pre-condition of recognition by the GMC of overseas qualifications for the purposes of full, or general, registration for the following reasons. First, it is anachronistic. We see no reason why the admission of overseas doctors to the medical register should require the assent of the Government. It seems unlikely that the Government would want to exclude the doctors of any particular overseas country on political grounds save in time of war, and in those circumstances special action

[1]Such rights may, of course, have been very substantially reduced through the review of qualifications to which we have referred in paragraph 202.
[2]Described in paragraph 175.

would be appropriate. Secondly, it is in our view highly unlikely that the present system secures any advantages to doctors trained in this country, although the Health Departments argued in evidence that "a system of reciprocity does result in a guaranteed outlet for our doctors who wish to widen their experience not only in fields of medicine and research in which it may be difficult to obtain particular experience in this country, but also in the field of different methods of organisation and administration of medical services". On this subject we preferred the view of the GMC: "It seems likely . . . that countries such as Australia, New Zealand, and South Africa would continue to accept British qualified doctors even if the requirement of reciprocity was removed from our Medical Acts: and the absence of reciprocity hitherto with the United States and several provinces of Canada has not prevented significant movement of doctors between the United Kingdom and those countries". We suspect that most developing countries would not wish to prevent assistance in the development of their medical services by United Kingdom doctors, and we assume that free movement of doctors within Europe will come if we stay within the European Economic Community. Thirdly, and most important, the present system is irrelevant to what ought to be the main function of registration. We agree with the following evidence of the GMC, who commented "the system of registration should be directed to the maintenance of standards in this country, and the presence or absence of privileges of practice in the country of provenance is irrelevant to this purpose".

206. We wish to comment, thirdly, on the exercise of the sort of discretionary powers which would be given to the GMC, particularly in relation to limited registration. While we support the conferment of such powers, it must be recognised that they would have a great effect on overseas doctors' livelihood. In order to avoid suspicion of unfairness, the basis of exercise of discretion on the granting and renewal of the rights to practise should be clearly and publicly defined. In this context, we noted the evidence of the Department of Health and Social Security, prompted by the circumstances of a particular case where further registration had not been granted.

> "When the question is whether [a doctor's limited] registration should be renewed, a doctor whose request for renewal is rejected is likely to feel a sense of grievance, which might be reduced if he is told in writing the general reasons why such a refusal is contemplated: it might be thought reasonable that he should be given an opportunity to reply before a final decision is taken not to renew, and it has been suggested to the Department that if his written comment were to show a reasonable case for doubts, the doctor should be given the opportunity of an interview".

We, like the Department of Health and Social Security, doubt whether any elaborate procedure is necessary but commend the suggestion that an overseas doctor whose right to practise might be withdrawn by the GMC should be given the opportunity to comment either in a letter or in person before any final decision on his registration is taken.

(*c*) *The GMC proposals for change not requiring legislation*

207. We support the GMC's proposals for immediate changes in the conditions under which temporary registration is granted, and wish to make only two points about them.

208. We consider that the changes should be kept under continuous and close review. In particular, evidence we received—and which we passed on to the GMC—convinced us that English tests ought to be the subject of special care with a view to ensuring that overseas doctors can communicate with patients as well as professional colleagues. We have referred already to dialects and euphemisms, but ordinary words—I *bumped* myself and it's *swollen* and *tingling* and I have a *throb* in my chest—will be difficult enough. While we are not suggesting that the test ought to involve the byways of surgery language, it ought be possible to be planned with the advice of those expert in the special communication difficulties involved.

209. Secondly, although we welcome the proposed improvements in the Clinical Attachment Scheme, we doubt whether they go far enough. In our view the present operation of the scheme is thoroughly inadequate. While 1,500 clinical attachments are carried out each year about 2,500 exemptions are granted; we welcome the proposal to give the GMC control over these. Apart from the unduly large proportion of exemptions granted, the Health Departments told us that "from late 1969 . . . up to the middle of 1973 only 156 (less than 5%) of overseas doctors were found unsatisfactory out of a total of about 3,700 completed attachments; 59 of these doctors subsequently completed other attachments successfully". The concentration of the new proposals on securing full replies from consultants is, in our view, highly desirable. We recommend, first, that very careful attention be given to the task of drawing up the document on which consultants are to provide their reports. In particular the form should force the consultant to think not only about the attached doctor's actual performance but also about the extent to which he has shown the capacity to adapt to conditions of practice in this country. What we doubt is whether consultants will find a two-week period adequate for a full and fair assessment. We recommend, secondly, that the most earnest efforts be made to increase the minimum period of uninterrupted attachment to one month. We recommend, thirdly, exploration of the possibility of attaching overseas doctors to teaching practices.

(*d*) *Specialist registration*

210. A novel problem in relation to doctors educated overseas arises from our recommendation that a specialist registration system be set up: doctors from overseas will of course wish to obtain such registration on the basis of education and experience gained overseas. (Doctors from overseas who wish to qualify in this country for specialist registration would of course be treated just like other doctors.) The terms on which overseas doctors may be granted such registration will require much careful thought and detailed study. We recommend that the basic pattern of the arrangements should be as for the registration of overseas primary qualifications: that is to say, the GMC, not accrediting bodies, should grant registration direct. We believe also that it ought to be a precondition of the grant of specialist registration that the doctor concerned has general registration in this country. The general assurances of competence which the new GMC proposals we have outlined will provide would thus operate in respect of doctors wishing to enter practice in this country at specialist level.

(e) *Special training for overseas doctors*

211. Before leaving this subject we should like to make one final remark. Where a doctor trained overseas is found deficient in some respect—medical knowledge, familiarity with the English language or any other reason—we believe in very many cases it would be a simple matter to remedy deficiencies of this kind. With the NHS under strain, as indeed it is, simple self-interest dictates that training programmes should be easily available for doctors falling into this category. We recommend that the Department of Health and Social Security should examine this problem immediately and undertake the responsibility for providing such programmes.

PART F: FITNESS TO PRACTISE CONTROLS AND OVERSEAS-TRAINED DOCTORS

212. This part is concerned with the arrangements whereby action can be taken against overseas doctors found unfit to practise. We deal with the matter separately from chapter 4 because the discretion explicit in temporary or, assuming its introduction, limited registration causes certain complications.

The present situation

213. Overseas-trained doctors with full rights of practice are subject to the fitness to practise controls described in part A of chapter 4. The application of fitness to practise controls to temporarily registered doctors, however, presents some special problems. Although Section 16 of the Medical Act 1969 formally extended the GMC's jurisdiction to temporarily registered persons, no case involving a temporarily registered person has so far been referred to the Disciplinary Committee. The principal reason for this is the relatively short duration of most periods of temporary registration granted by the GMC. These are linked to the duration of appointments in the hospital service and if a doctor is dismissed from his appointment, the registration granted in respect of it automatically lapses. In consequence the matter to be considered by the GMC is normally not whether to terminate through application of its control procedures a period of registration still current, but whether the GMC should exercise its discretion to grant further periods of temporary registration to the doctor. This is decided by the GMC's Overseas Committee or by a Sub-Committee of it. In practice the sort of "cases" which most frequently have to be considered in this area of the GMC's work are cases where temporarily registered doctors have been convicted in the courts of offences involving abuse of drugs, alcohol or dishonesty. The circumstances of such cases vary a good deal in gravity, and they are considered individually. If the circumstances of the case appear to make it desirable, an oral hearing is arranged at which the doctor has an opportunity to address the Committee and to be legally represented before a decision is reached.

The effect of our conclusions

214. We envisage no difficulty in the application of the normal fitness to practise controls to overseas-trained doctors with general registration. This would merely be a continuation of the present situation. The problems outlined in the previous paragraph would apply, however, to overseas doctors

with limited registration. We believe that a procedure similar to that obtaining now for temporarily registered doctors should be observed. While this might appear to place a doctor with limited registration at a disadvantage compared with his generally registered colleague, we consider that a less formal system is inevitable, given our acceptance of the discretionary nature of limited registration and, in particular, the likelihood that the conditions on which the doctor was granted limited registration might no longer apply—therefore the limited registration would lapse—by the time a case came to the attention of the GMC. We merely observe that, if a category of registration granted at the discretion of the GMC is introduced, no final decision should be taken on the continuance of a period, or the granting of further periods of limited registration, in cases where misconduct or a conviction was involved, without affording the doctor concerned the opportunity to put his case at a hearing conducted in a similar way to the hearings before the fitness to practise committees.

PART G: THE EUROPEAN ECONOMIC COMMUNITY

215. The type of control described elsewhere in this chapter will not be applicable to doctors from other countries in the European Economic Community. We understand that, assuming the Community Medical Directives come into force, the GMC will be obliged to allow full rights of practice to doctors from the other member states who are both nationals of a member state and graduates with a recognised qualification obtained in one of the member states. We understand that these arrangements will apply both in the case of doctors wishing to become established in the United Kingdom and of doctors who merely wish to provide services on a temporary basis. The manner of imposing obligations attendant upon membership of the Community will be for the Government to consider when framing the necessary legislation. The obvious problem is that of ensuring mutual confidence between member states in the quality of their respective doctors. We have been told that what is likely is that certain criteria on quality will be laid down in the Directives themselves and that a European Advisory Committee on Medical Training will be set up to keep under review the quality of training and developments in medical education throughout the Community. If changes occur in training so that the requirements of the Directives are no longer met by a particular university, the Commission—and through them the member states concerned—will be informed to that effect by the Advisory Committee. (What happens then is not quite clear.)

216. We see this as a transitional situation: European countries are to accept other countries' standards, that being the obvious phase lying between the determination of standards on an exclusive national basis, and the determination of standards on a European basis. Eventually the European Advisory Committee, or a successor organisation, may one day displace the GMC and other national bodies, and standards for medical education will be determined on a European basis by a properly constituted European body.

217. Generally there is no doubt that the negotiations within the Community to enable free movement of doctors inside the Community will limit drastically

the power which the GMC must exercise over doctors trained overseas so far as the member states are concerned. It is too early to say how this situation will develop but the GMC will have to remain vigilant to see that the privileges which will be extended to doctors in Community countries to practise here are not abused to the degree that they weaken the GMC's duty to protect patients. We have no reason for believing this will be the case; we merely remind the GMC at this stage that nothing undertaken by Governments must undermine the duty it has. We should, however, like to put a more constructive view, which applies to all doctors trained abroad and in particular to the specially privileged doctors of the Community. We in this country have no monopoly of wisdom so far as the practice of medicine is concerned, and it is our belief that the negotiations which are now going on in the Community should be regarded as an opportunity to raise standards in all the member states. Doubtless there will be the usual difficulties, and sometimes serious difficulties, which attend all new initiatives of this kind. But they should not blind us to the opportunities which our new relationship with Europe offers in this field.

218. There is little we wish to say on more specific points. We hope, *first*, that some means can be found to ensure that incoming doctors are familiar both with English and with professional ethics and practice in the United Kingdom. We understand that there may be difficulties in making a period of adaptation compulsory but we hope that agreement can be reached on this matter. As regards, *secondly*, the control of fitness to practise of doctors coming from other member states (even those coming here only for a very short period) we understand that it will be possible for the GMC to treat them in exactly the same way as they would any other doctor with full right of practice in this country. We welcome this. We also approve the relevant part of the Directives which provide that, in the event of fitness to practise action being taken by the GMC against a doctor from another member state, the GMC may, in the case of an established doctor, and will be obliged, in the case of a doctor providing services on a temporary basis, to inform the competent authority in the country of origin of the action taken and the reasons for it. We understand, *thirdly*, that members have been asked to inform the General Secretariat of the Council of Ministers as soon as possible of the body or authority competent to register specialists in their countries, so that this information can be included in the Directives, and that the Government has refrained from making such a nomination pending the issue of our report. We are in no doubt that for Community purposes the GMC ought to be the competent authority for the registration of specialists in the United Kingdom.

219. The harmonisation of the specialist standards of this country with those of the Community is potentially awkward. We understand that the Directives prescribe a minimum period of training for each specialty, and that these minima are all exceeded by the current minimum periods required for specialist accreditation in this country. Evidently, therefore, doctors from this country *could* be put at a disadvantage compared with their Community colleagues. It is beyond the scope of our inquiry to make recommendations in this field, though the importance—if only to our specialist registration proposals—of a solution being found is clear. We believe that this must be a matter in which

the GMC must take a lead, and we have no doubt that this is one of the areas where the GMC will have to use its informal powers,[1] once it has an established standing in specialist education, to find a solution.

PART H: CONCLUSIONS AND RECOMMENDATIONS

Our principal conclusions in Chapter 3

(18) The NHS is very heavily dependent on overseas-trained doctors (paragraph 169).

(19) The range of standards of overseas-trained doctors allowed to practise in this country projects substantially below that of home-trained doctors, and there are particular problems of integration for overseas doctors (paragraphs 179–188).

(20) Overseas-trained doctors have made an immense contribution to the development of the NHS, and in considering changes in the arrangements for admitting overseas-trained doctors to the medical register, the position of a group which has been encouraged by successive Governments to come to this country to help maintain the NHS must be treated sensitively (paragraph 195).

(21) No difficulty should arise over the application of fitness to practise controls to overseas-trained doctors (paragraphs 212–214).

Our principal recommendations in Chapter 3

(31) The GMC should register only those overseas-educated doctors whose standard is up to the minimum required of a medical graduate in this country (paragraphs 189–192).

(32) It would be undesirable to introduce a qualifying examination at first degree level as a condition of admission of overseas-trained doctors (paragraphs 193 and 194).

(33) The GMC's proposals for new arrangements to control the admission of overseas-trained doctors should be implemented (paragraphs 196–209).

(34) Arrangements should be made for affording specialist registration to overseas doctors on the basis of education and experience obtained overseas (paragraph 210).

(35) The Department of Health and Social Security should mount a study of training programmes for overseas doctors (paragraph 211).

(36) The special arrangements which are being devised for the mutual recognition of medical qualification within the European Economic Community are to be welcomed (paragraphs 215–219).

[1]See paragraphs 140 and 141.

CHAPTER 4: FITNESS TO PRACTISE

PREAMBLE

This chapter deals with the right of doctors to remain on the medical register. At present, a doctor's name may be removed from the register only if he has been convicted of a criminal offence or is found to have committed serious professional misconduct. We have considered "fitness to practise" in a rather wider sense. Registration is robbed of its meaning as an indication of the practitioner in whom the public can trust unless that registration can be withdrawn from all those in whom trust for any reason can no longer be reposed. We therefore share the general view of the medical profession that control should also be exercised over those doctors whose health, mental or physical, is such as to call into question their continued right to practise. We commend the principle on which the existing procedures for controlling doctors who are accused of professional misconduct are designed, namely that they follow a judicial rather than an administrative model. This principle should we believe be applied to questions of fitness to practise in the wider sense; in other words, a doctor should always have the right to present his case formally and to be given a fair hearing before his name can be removed from the register. We further recommend that the GMC should be enabled to play a more active rôle than hitherto in obtaining information about doctors' fitness to practise. We have welcomed the willingness of the GMC to review its practice in several areas during the course of our inquiry. Indeed, a number of criticisms that were levelled at the GMC in evidence to us have already been met by the GMC's own actions.

PART A: THE PRESENT SYSTEM OF CONTROLLING FITNESS TO PRACTISE

The legislative basis of the GMC's control of professional conduct

220. The medical legislation[1] provides for the control of professional misconduct by the GMC. Section 33(1) of the Medical Act 1956 reads:

> "Where a fully registered person—
>
> (*a*) is found by the Disciplinary Committee to have been convicted . . . of a criminal offence; or
>
> (*b*) is judged by the Disciplinary Committee to have been . . . guilty of serious professional misconduct,
>
> the Committee may, if they think fit, direct that his name shall be erased from the register, or that his registration therein shall be suspended . . . during such period not exceeding twelve months as may be specified in the direction".

The legislation gives the GMC standing to act only in relation to convictions and to serious professional misconduct. It gives no guidance on what constitutes serious professional misconduct.

[1]More specifically Sections 32–38 of the Medical Act 1956 as amended by Sections 13–16 of the Medical Act 1969. Section 33(1) of the Medical Act 1956 was amended by Section 13(1) of the Medical Act 1969.

The nature of the GMC's control of professional conduct

221. Because there is no legislative guidance on what constitutes serious professional misconduct, the GMC is the arbiter of such misconduct; and this position has been recognised by the courts. The most commonly quoted judgment[1] is one of 1894 by Lord Justice Lopes as follows:

> "If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect".

In other words the test of professional misconduct is, to adapt another judicial pronouncement, this time by Lord Justice Scrutton, whether doctors have broken the laws written or unwritten governing the medical profession. In short the medical legislation leaves solely to the judgment of the GMC, acting through its Disciplinary Committee, the determination of which criminal offences or what conduct should be judged to merit reconsideration of a doctor's registration.

222. Since the Medical Act 1950 came into force, a decision by the GMC to erase a doctor's name from the Register has been subject to a right of appeal to the Judicial Committee of the Privy Council.[2] The way the legislation makes the GMC the arbiter of misconduct does, however, mean that an appeal founded solely on the assertion that the GMC's finding of misconduct was wrong—as distinct from appeals founded on arguments of law about the conduct of the hearing—is unlikely to succeed. This reflects the natural unwillingness of the courts to overturn the view of a body composed predominantly of professional men on what constitutes misconduct in the profession. The introduction of a right of appeal has not, therefore, altered the essentially adaptable and common-law nature of the definition of professional misconduct which we have described.

223. We have referred to the written and unwritten laws of the medical profession, and at Appendix B is the guidance at present issued by the GMC on these "laws". Three elements may be noted in the matters which may give rise to action. First is the ordinary law of the land. Doctors are directly disciplined by the GMC following criminal convictions, notably in cases involving offences against the dangerous drugs legislation or abuse of alcohol. Secondly, charges of serious professional misconduct arise from doctors' responsibilities to patients; these days the bulk of such cases originate following NHS control action. Thirdly, there are matters which neither contravene the law of the land nor necessarily harm patients but are "professional" offences. Advertising is an example of such an offence.

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[1]This judgment refers to "infamous conduct in a professional respect" which was in substance the term in the legislation prior to the passing of the Medical Act 1969. The present phrase "serious professional misconduct" inserted by that Act was, however, intended to convey the same meaning as the previous one, while dispensing with the perhaps inappropriate word "infamous".

[2]Before the Medical Act 1950 came into force a more limited review of the GMC's disciplinary action could be obtained by means of the so called "prerogative writs". The Judicial Committee of the Privy Council whose members include the Law Lords is in effect the highest appeal court in the land sitting under a different name.

The procedure for adjudging professional conduct

224. Appendix C describes the procedure followed by the GMC in considering disciplinary cases. The Disciplinary Committee is required by the medical legislation to make rules of procedure for the consideration of convictions and allegations of serious professional misconduct. The point of these rules, which are embodied in subordinate legislation, is to secure that cases are dealt with in a fair and orderly fashion.

The GMC's sources of information on professional conduct

225. The GMC can act only when information is brought to its notice. The following table, provided by the GMC, shows, in relation to cases considered by the Penal Cases Committee and the Disciplinary Committee during the whole of 1973, the original source of the GMC's information in each case.

	Convictions in criminal court	Cases of professional misconduct						Total
		Court Cases where (*a*) no conviction	NHS	Other Official Body (*b*)	Newspaper Reports	Private Complainant (*c*)	Voluntary confession by doctor	
Penal Cases Committee	59	3	9	5	1	14 (10)	1	92
Disciplinary Committee(*d*)	24	2	7	3	1	6 (4)	—	43

Notes: (*a*) The figures in this column relate to cases where a doctor was found guilty in a Criminal Court, but because he was conditionally discharged or placed on probation the GMC was prevented by the Criminal Justice Act 1948 from treating the case as a conviction.

(*b*) Home Office, Pharmaceutical Society, or Health Departments (concerning matter other than NHS disciplinary proceedings).

(*c*) The figure in brackets denotes cases where a private individual submitted a formal complaint with statutory declarations. The totals include other cases where the matter was investigated by the Solicitor to the GMC after some information had been received from a private individual.

(*d*) The figures for the Disciplinary Committee include six applications for restoration after erasure in a previous year, and a number of other cases in which judgment had been postponed in an earlier year.

It will be seen that by far the greatest number of cases considered were cases of conviction. These are commonly reported to the GMC by the police although in a few cases it first learned of them from press reports; and in the case of prosecutions for false certification undertaken by the Health Departments, the GMC is informed by the Departments. Of these cases of conduct the great majority also arose from information sent to the GMC by the Departments; only a few arose from private complaints. Complaints from patients which lead to disciplinary action commonly relate to abuse of professional position to commit adultery, or occasionally to breach of professional confidence, or to dishonest practices by doctors. Complaints by individual doctors of advertising or canvassing by other doctors also occasionally result in disciplinary action although no cases of this kind arose from complaints

received during the period in question. Cases of conviction reported to the GMC are almost invariably considered by the Penal Cases Committee.

226. The following table, also provided by the GMC, illustrates the likelihood of action being taken on *cases other than convictions* of which information or complaints are sent to the GMC. The figures shown relate to action taken on information received in the seven months April to October 1973.

Number of cases received from:		Number of these referred to: Penal Cases Committee	Disciplinary Committee
Official bodies ...	27 (*a*)	8	3
Other doctors	26	0	0
Members of public ...	289	5	1
Total	342 (*b*)	13	4

Notes: (*a*) NHS authorities provided 26 of these cases.

(*b*) What precisely happened to these 342 cases could be shown only at the expense of a very detailed explanation, but about 40 were rejected on the grounds of the writer's incomprehensibility, obvious mental disorder, or anonymity, about 120 were not regarded as raising a question of serious professional misconduct, and about 130 were referred to NHS authorities as raising a matter of the standard of NHS services. The remaining 40 or so were cases where either the GMC unsuccessfully sought further information, or referred the case to the conduct committees as shown in the table.

At first reading it may appear odd that the number of cases referred to the Disciplinary Committee in the second table is so much lower than those shown in the first, but of course the second table deals only with conduct cases; it relates only to information received within a seven months' period whereas the first table covers a year; and the figures in the first table, as indicated in the notes to it, include figures of cases originally considered before 1973 in which judgment was postponed or suspension ordered with a subsequent reappearance, and also six applications for restoration.

227. The practice governing police reports of convictions of doctors was revised recently. The police are at present instructed to report current convictions of doctors to the Registrar of the GMC "particularly those involving violence, indecency, dishonesty, drink or drugs, because they may reflect on a person's suitability to continue in his profession . . . Minor offences, eg. road traffic offences for which there is no power to disqualify from obtaining or holding a licence, will not generally be included".[1]

228. The NHS arrangements for conveying information to the GMC are summarised in the next two paragraphs.[2] The arrangements for general practitioners differ greatly from those for hospital doctors. This reflects the way in which the two groups provide their services to the NHS. General

[1]Statement by the Secretary of State for the Home Department; 14 June 1973.

[2]A full description of the NHS control procedures for doctors, the arrangements governing police reports of convictions and the position of doctors in relation to the dangerous drugs legislation is set out in Appendix D.

practitioners provide their services under contract[1] and are subject to control under a statutory system of tribunals at the head of which, and receiving details of all "convictions", stand the Secretaries of State for Social Services, for Scotland, and for Wales. NHS hospital doctors are, on the other hand, employed directly by NHS authorities. Control of hospital doctors is not backed by statute and the responsible Government Ministers play no central rôle in relation to the standards of individual doctors. This difference is, as will be seen, reflected in the arrangements for provision of information to the GMC.

229. The Secretaries of State have agreed with the British Medical Association that the GMC should be notified of the names of general practitioners in the following circumstances. First, a general practitioner who, following NHS statutory proceedings, is prevented from acting as a principal general practitioner anywhere within the NHS, is reported to the GMC. Secondly, the GMC is informed of certain cases where general practitioners are found to have failed to observe their conditions of service within the NHS. The cases reported are those involving:

(*a*) irregular certification under the National Insurance Regulations;
(*b*) irregular charging of fees to patients;
(*c*) fraud or improper claims to fees;
(*d*) canvassing or gaining of patients by unethical means;
(*e*) certain cases of overprescribing of addictive drugs;
(*f*) the more serious clinical cases (that is, failure to give proper treatment, failure to visit, failure to refer to hospital).

The majority of cases reported to the GMC fall within the last category.

230. So far as NHS hospital doctors are concerned, there are no settled arrangements for notifying cases to the GMC. The following guidance has however, been given to hospital authorities by the Department of Health and Social Security:

> "In order that the statutory bodies responsible for professional discipline may be aware of convictions in the courts leading to the dismissal or resignation of members of the professions concerned, the Minister asks that in every case the hospital authority should send a factual report of the charges and sentence to the disciplinary body. A list of the principal disciplinary bodies concerned is appended. A hospital authority is, of course, still free to report to the appropriate body the facts of any other dismissal or resignation where, in the authority's view, these facts should be made known to the body, even though there has been no conviction in the courts. It is for the professional body concerned itself to decide what action, if any, to take on a report".

In practice NHS hospital authorities do not notify convictions and very rarely report other matters to the GMC. Of the 26 cases in the table reported to the GMC by the NHS, only three appear to have been reported by hospital authorities.

[1]The contract is with the Family Practitioner Committee. The Committees, in making contracts, do not strictly "employ" general practitioners. When we refer to NHS employing authorities in the rest of this chapter we should, however, be taken to include Family Practitioner Committees.

General points on the system just described

231. We draw attention to the following points on the controls we have just described. First, a doctor's name may be removed from the Medical Register only if he has been convicted of a criminal offence, or is found to have committed serious professional misconduct: it is a narrow basis of control and does not take account of other factors—such as mental health—which might affect a doctor's fitness to practise. It is also a control which is judicial in character, not administrative; that is, the GMC can remove a doctor's name from the register only after an inquiry modelled on the judicial process at which the doctor may be represented much as he might be represented in the courts. The third general point to which we wish to draw attention here is that only to a limited extent does the GMC set out to discover information about doctors' fitness to practise.

PART B: OUR GENERAL APPROACH

The initiation of fitness to practise action

232. We recommend that the GMC should be able to take action in relation to the registration of a doctor whose condition or conduct requires it in the interest of the public. By condition we mean mental or physical health including addiction to any drug. By conduct we mean the doctor's behaviour towards his patients, the general public, and towards his colleagues. In the interest of the public we include two closely interwoven strands: the particular need to protect the individual patient, and the general need to maintain the confidence of the public in their doctors.

233. Our reference in the previous paragraph to "the *registration* of a doctor" involves an important point concerning the general scope of the GMC's control of fitness to practise. It is possible to imagine a GMC which, in some sense, might be a patients "ombudsman", obliged to look into every aspect of doctors' professional dealings. We do not think this would be desirable, and believe that the GMC should take action only in relation to matters which are sufficiently serious to raise the question of a doctor's continued right to practise. To do more would, in our view, disperse effort which should be centred on the crucial rôle of the GMC in this field: looking at the doctor whose condition or conduct represents a general *public risk*. Furthermore, scrutiny by the GMC of every aspect of doctors' professional dealings would entail considerable involvement in the day-to-day running of the NHS which has its own arrangements for considering complaints about the standard of service provided by doctors employed within it. We think the GMC should take care to explain why it cannot look into every action by a doctor brought to its notice, and that it must be concerned only with matters which question the continuation of the doctor's registration. A particular problem is the interaction of GMC and NHS procedures. We understand that persons who complain to the GMC are frequently told to pursue their complaints with the competent NHS authority, which they may find frustrating particularly if the referral is inaccurate. We endorse, therefore, the following comment from the National Association for Mental Health (Mind) who told us, "while it is proper that disciplinary action should be taken on different

levels by different bodies, this situation is confusing for the public, and much greater initiative could be shown by [the GMC] in making clear its disciplinary rôle *vis-à-vis* [NHS authorities]".

234. The GMC's actions towards those unfit to practise should be directed to the protection of the patient, not the punishment of the doctor. This should, in our view, be the case even where the question of his fitness to practise arises on account of professional misconduct. For a doctor to have his name erased from the register, and to be in effect deprived of his livelihood, is a very serious penalty, but that it is a penalty is a side effect rather than a purpose of regulation. It is important that members of the GMC, in any fitness to practise dealings, should constantly bear in mind that their duty is to protect the public. If punishment were to be the purpose of control, then members of the GMC might be swayed to deprive a doctor of the right to practise on grounds other than a dispassionate assessment of the public interest. Only in the sense that punishment may be regarded as a sanction to back up the rules of society and deter others from breaking such rules do we regard it as appropriate to the regulation of fitness to practise. Certainly an atmosphere of punishment may, furthermore, discourage members of the profession or of the public from notifying the GMC of matters which ought to be brought to its attention; especially, for example, of mental illness which also involved professional misconduct. We have tried to avoid words like "discipline", "punishment" and "offence" in this chapter as a contribution towards ridding the GMC's control of fitness to practise of an aura of punishment. We recommend that the GMC be scrupulous in the same manner.

The scope of our approach contrasted with the scope of the present system

235. The present GMC controls of fitness to practise are narrowly based and relate only to professional conduct and to criminal convictions. We believe that the scope of the GMC's responsibility should be enlarged to include the mentally or physically sick doctor, and we set down our views on professional conduct and the sick doctor in later parts of this chapter. Secondly, we emphasise that the present GMC system is judicial rather than administrative. We think it is right that a doctor should be deprived of his livelihood only after scrupulously conducted inquiry; and this has coloured very much our approach to the fitness to practise procedures to be adopted. Finally, under the present system the GMC *seeks* information about doctors' fitness to practise only to a limited extent. On the whole we believe that more information about doctors should come to the GMC. This theme recurs at several points in this chapter and is particularly relevant to the material on information reaching the GMC.[1]

Control of fitness to practise through re-licensure

236. The term re-licensure is applied primarily to schemes making continued registration dependent on regular tests of medical knowledge and skill, or attendance at refresher courses, or scrutiny of clinical work; but it is also applied to schemes making continued registration dependent on regular health tests,[2] or indeed to almost any sort of regular scrutiny of doctors. We have

[1]Part C of this Chapter.

[2]See paragraph 242.

set down our views on re-licensure in chapter 2, because the main theme of re-licensure is making continued registration dependent on keeping up to date with developments in medical knowledge. We stress here that schemes of re-licensure could only supplement the controls of fitness to practise which we recommend; they could not supplant them.

The motive power of fitness to practise controls

237. We have already explained that we hold firmly to the view that the control of the medical profession will best be exercised primarily by the profession itself. The maintenance of high standards in the professions of medicine, and consequent public trust, are as much in the interests of the profession as those of the public. In other words the best guarantee of the public safety is the self-respect of the profession itself, and we should do nothing to weaken that self-respect.

238. Of course this underlines the responsibility of the colleagues of a doctor for his conduct and—more particularly—his condition, because it is crucial to the control of fitness to practise. We develop the point in the next part of this chapter.

PART C: INFORMATION ON FITNESS TO PRACTISE

239. Of the practical problems of controlling fitness to practise, one of the most difficult is what measures should be taken by the GMC to obtain information about doctors. We believe that the responsibility of the medical profession which we have emphasised must find expression in a greater willingness to take action in relation to colleagues whose condition or conduct requires it, and in particular that the profession must accept an increased provision of NHS information to the GMC.

The medical profession

(*a*) *The inhibiting effect of professional loyalty*

240. There is an understandable reluctance among doctors either to criticise their colleagues' professional conduct or to take action where their colleagues' condition may require it. Such an attitude reflects the store set by loyalty in a fairly closely knit profession whose members are not only very much aware of the distress that may be caused by the suspicion that a patient did not receive the best possible care, but conscious also of their own fallibility. Taken too far, such reluctance may represent a considerable inhibition on the effective control of fitness to practise. The Medical Defence Union, in the context of controls on advertising and canvassing, made the following remark:

> "It was previously supposed that reporting doctors to the GMC was a praiseworthy activity. Nowadays it incurs odium and members protest that defence societies are there to protect doctors not to attack them".

Although this relates to particular offences which many doctors may not regard as specially significant to fitness to practise, it does suggest that *unthinking* mutual loyalty may be on the increase. The problem of the provision of information on doctors' conduct, and even more their health, must be considered against this background.

(*b*) *Scrutiny of doctors*

241. The reluctance to report colleagues has naturally led us to consider whether doctors ought to be subjected to definite scrutiny, with a view to action where any evidence of unfitness to practise is adduced. We have indicated[1] that we do not wish to prejudice consideration of re-licensure schemes which involve large scale continuous scrutiny of the medical profession. We do wish to say something about two other devices for improving the GMC's information about doctors' condition and conduct.

(*c*) *Regular health tests*

242. We have recommended that the GMC's responsibility should be enlarged to include action in relation to the mentally or physically sick doctor.[2] The radical way of securing information about the health of doctors would be to insist on their undergoing regular medical examinations. Although such a scheme would no doubt lead to the detection of some otherwise undiscovered mental and physical unfitness to practise, we believe this proposal has two main disadvantages. First, it would not ensure that all cases were identified. In particular, effective psychiatric screening would be technically extremely difficult. For example, the detection of doctors who were suffering from alcoholism or drug dependence would require both the willing co-operation of the subjects themselves and of doctors' relatives or colleagues who could supply additional evidence. Sick doctors often do not recognise their disability or appreciate its effect on their practice. Such doctors might well be those least likely to give the co-operation that would make screening effective. Secondly, to provide a thorough medical examination of all doctors would involve considerable work for a large number of examiners. In our view the balance of resources required, against the result likely to be achieved, is such that periodic tests cannot at present be justified. An occupational health service for NHS employees would, incidentally, throw up some cases of this kind but by no means all.

(*d*) *A statutory duty to report unfitness to practise*

243. A second possible way of increasing the provision of information to the GMC would be to impose a statutory duty on the general public, the medical profession, or on public bodies to report doctors whom they suspected of being unfit to practise. We considered this because we noted that a number of other countries have adopted this sort of approach, notably in respect of a duty on the medical profession to report colleagues' ill-health. For example, section 55 of the Medical Act of British Columbia, which sets out the procedure for considering cases of ill-health, begins, "Every member registered under this Act shall report to the registrar the condition of any person registered under this Act whom he, on reasonable and probable grounds, believes to be suffering from a physical or mental ailment or emotional disturbance or addiction to alcohol or drugs that, in his opinion, if he is permitted to continue to practise medicine or surgery, might constitute a danger to the public or be contrary to the public interest . . ."

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[1]In paragraph 163.

[2]See paragraph 235.

244. We think it quite obvious that a statutory duty to report *misconduct*[1] is impracticable: the rôle of the informer is too uncongenial to place any person or body under the duty of being one.

245. A statutory duty to report doctors' *ill-health* is not so easy to dismiss. To impose a duty on every member of the public would of course be quite impracticable: apart from the resentment of the medical profession of such a measure, it seems evident that the public would not accept such a duty—and indeed we suspect that patients may, out of loyalty, be more prepared to shield than to report sick doctors. To place public bodies, particularly NHS authorities, under such a duty would complicate such bodies' relations with the doctors they employed. For example a sick doctor might be unwilling to reveal his condition to his employing authority because he knew that the authority would be obliged to report the fact to the GMC. Contrariwise, an employing authority might be reluctant to take informal supportive action at the onset of a doctor's illness because it would be obliged at the same time to report this illness to the GMC. We do not believe that it would be worth paying such a price for any countervailing advantage there might be in relation to coping with sick doctors.

246. We have considered especially carefully whether a duty ought to be imposed on members of the medical profession to report the ill-health of their colleagues. Medically qualified persons will be in the best position to notice a colleague's problems and able to assess accurately the effect of his illness on his practice. The imposition of such a duty would, moreover, stress the profession's responsibility towards its members, and might lend power to a doctor's attempt to persuade a colleague to seek treatment voluntarily, the doctor being able to explain that he was under a statutory duty to take further action if the sick doctor refused to accept medical advice.

247. Three factors have influenced our eventual judgment that this would not be a wise course of action. First, the imposition of such a duty by law, even accompanied by a penalty for breach, could in practice seldom have more than a declaratory effect: that is to say, one cannot comfortably envisage the criminal prosecution of a doctor for failing to report a sick colleague. This being so, it seems better to try to persuade doctors of their duty than to impose a virtually unenforceable legal obligation. Secondly it would be necessary to exclude a doctor's own medical advisers from such a duty, otherwise sick doctors might be reluctant to seek treatment. Once this is admitted, the argument that a duty on doctors to report sick colleagues would assist in persuading the sick colleague to seek assistance—the factor we mentioned at the end of the previous paragraph—loses its force. Thirdly, and more generally, a statutory duty might introduce an unwelcome rigidity of response, and, in particular, interfere in the delicate matter of persuading a colleague suffering from a disabling illness to seek appropriate treatment.

[1]We mean of course fresh and uninvestigated misconduct. Misconduct which has been investigated already by the police or NHS is reported to the GMC, though not because of a statutory duty to do so.

248. We do, however, believe that in certain cases it might be appropriate for the GMC to take action against a doctor who took no action to protect the public from a sick colleague. In other words, we believe that in some circumstances it could constitute serious professional misconduct not to take the appropriate steps to prevent a sick colleague from being able to do harm.

(*e*) *Professional loyalty—the ideal*

249. While we do not recommend measures to increase the active scrutiny of the fitness to practise of the medical profession, we do wish to stress, as strongly as we can, the profession's responsibility to co-operate with the GMC over the control of fitness to practise. We have mentioned a doctor's responsibility to the public, to his profession, and to his colleagues. The doctor's responsibility to the public, who may be at risk from a medical practitioner's conduct or condition, is obvious enough. Similarly, doctors have a responsibility to their profession to maintain the standards of the profession. Doctors have also a responsibility to a sick colleague, who may well be the person who suffers most—we have seen evidence that this has happened—if matters are allowed to drift to the point where he is beyond eventual restoration to the practising profession. We believe that all members of the medical profession ought to have careful regard to these responsibilities and consider in the light of them what professional loyalty really entails.

250. There is a corollary which we develop in part E of this chapter. The new health machinery which we recommend for the GMC must, as must NHS controls for similar purposes, be supportive in tone. It would be unfair to ask the colleagues of a doctor to take action where a doctor's condition required it and then see the doctor caught up in a machine which was merely punitive in effect.

The passing of information from the NHS to the GMC about fitness to practise

251. Since the majority of doctors work within the NHS, it is inevitable that the GMC will look to the NHS as a major source of information about the fitness to practise of doctors. This raises important issues of principle and practice since both patient and doctor have to be protected in matters of this kind. The GMC as protector of the patient must have the willing co-operation of the NHS in those cases where it is required. The doctor, on the other hand, must be protected from an abuse of information from his employer based perhaps on the frivolous complaint of a patient. We recommend that there should be a thorough discussion of this issue by the GMC, the Health Departments and representatives of the profession, and to guide that discussion we offer the following remarks.

252. We should first comment on the duty of those working in the NHS and the Health Departments (both doctors and administrators) in the matter of fitness to practise. Sir George Godber, in giving evidence to us referred to a number of individual cases, well substantiated in his view, where no action could be taken by the GMC since no complaint had been made to them. He cited, for example, a case which had come to his notice at the time, of a girl who had choked to death while left unattended when she was still anaesthetised

after an operation. We see no reason why those working in the NHS and the Health Departments should feel in any way inhibited from taking action, including, where appropriate, reporting to the GMC in cases where they have good reason to believe that patients are at risk, no matter how the information has come to them. Indeed, in the case of doctors possessing information of this kind we should go further and say that they have an ethical duty to act.

253. Where the case concerns an NHS doctor we should not expect the GMC to be involved until after the appropriate NHS procedures have been invoked and result in a finding questioning the fitness to practise of the doctor concerned, whether through ill-health or for any other reason.

254. We see the possibility of conflict arising between the Secretary of State in his rôle as employer and in his rôle as an officer of Government with certain statutory powers and duties laid upon him by Parliament; for example, in the collection of statistics on abortion cases. We have considered the recommendation of the Lane Committee[1] that the Abortion Regulations should be amended so as to give authority to the Chief Medical Officers to disclose information derived from abortion notifications to the GMC for the purpose of investigating serious professional misconduct. We would not condone special scrutiny of those notifications with the specific intention of trying to detect evidence of misconduct, although if an irregularity was obvious, we do not think the Chief Medical Officers should feel prevented from drawing it to the attention of the GMC. Our general view is that expressed in the previous paragraph, that the primary duty of officers of the NHS and the Health Departments is to the patient and that they should not be inhibited from acting when they believe patients to be at risk. In the discussion we have suggested, it will be important to keep in mind the present powers given to any party to proceedings before the Disciplinary Committee[2] to obtain writs from the High Court addressed to witnesses ordering them to attend a hearing and to bring documents if ordered to do so. The Secretary of State and his officers are naturally not exempt from such writs, nor can they be. Any such exemptions would, in our view, be seriously prejudicial either to the defendant doctor or to the GMC in its rôle as protector of the public.

The desirability of the GMC playing an active rôle in relation to professional misconduct

255. The GMC told us that, throughout its history, its reliance on outside information, and the lack of any defined duty to institute misconduct proceedings of its own volition, have given rise to a number of problems. Occasionally an individual will be so incensed by the conduct of a doctor as to be prepared to act as a private complainant and both to lay a complaint and prosecute it before the Disciplinary Committee. The Medical Defence Societies also have occasionally assumed this rôle in the past but only in relation to advertising or canvassing by doctors, not members of the society in question, which appears prejudicial to the interests of their members. Over a large range of professional conduct it is not the duty or the practice of any professional body or

[1]Report of the Committee on the Working of the Abortion Act. Cmnd. 5579, paragraph 478.
[2]Conferred by the Medical Act 1956; Fourth Schedule; paragraph 5.

public authority to collect evidence and to prosecute proceedings. Since the standard of evidence required to prove a charge before the Disciplinary Committee equates with the standard of proof required in a criminal court the institution of proceedings involves very considerable work and expense. Over the years, the GMC's attitude has varied somewhat on the question of the degree to which it ought to institute proceedings in the absence of a formal complaint from an outside source. In the earlier period of the GMC's history, the tendency was to take no action in the absence of either a complainant prepared to assemble the evidence and to present it at a hearing, or of the receipt of information accompanied by all the evidence required for the GMC's purposes, or of information from a person acting in a public capacity. During the last 10 or 15 years the GMC has taken the view that if it continued to limit its activity in this way, types of professional misconduct which gave rise to public criticism would not be dealt with. These included the irresponsible prescription or supply of drugs of addiction otherwise than in the course of bona fide treatment, and touting or advertising for patients following the passing of the Abortion Act 1967. The GMC has, accordingly, in these and some other fields latterly been prepared to incur considerable expense in collecting evidence and in prosecuting cases where it has received information which suggested that the conduct of a particular doctor should be investigated. We believe that the GMC's action in this respect is entirely justified and that it should be continued in the interest both of the public and of the profession.

256. Indeed, in our view it is important that the GMC should be able to assess as quickly as possible which complaints are substantial so that action, including the dismissal of unfounded allegations, can be taken without undue delay. We recommend that the GMC should set up a small unit, staffed by its own employees, possibly under the supervision of a medically qualified official, to investigate allegations against doctors.

257. We believe that a unit such as we suggest has the following advantages. First, experience has shown that the GMC needs to conduct investigations: at present it uses private enquiry agents, which practice must, we think, have increased the profession's suspicion of current procedures. The unit, as a specialist body within the GMC, would be able to develop a good understanding of the circumstances under which doctors practise and would therefore make enquiries with appropriate discretion. Secondly, the GMC would be in receipt of better information than at present. There should in particular be less risk of a doctor's being unnecessarily subjected to the worry of a formal hearing. Finally, such a unit would contribute to the openness of the fitness to practise procedures. The doctor concerned would from the first be aware that the GMC was investigating a complaint and would have knowledge of the nature of the information available to the GMC. Indeed, we think the existence of a formal unit would enable the profession as a whole to scrutinise and comment more easily on the investigation of complaints by the GMC than is possible at present.

258. We appreciate that the establishment of such a unit would be a matter of concern for the profession, whose members might well consider that a more active rôle by the GMC would be an unwelcome addition to the considerable amount of scrutiny to which their actions are already subject. We hope that

the details we give below will convince the profession that a responsible unit of the kind we recommend is now necessary and that, in the end, it will be in their interests that it should exist.

259. We envisage that employment of the unit would be under the personal direction of the President of the GMC.[1] Where the President was satisfied that a case required further clarification, and had informed the doctor accordingly, he would refer the matter to the unit. This would apply principally to complaints from private individuals as information from such bodies as the police or an NHS authority might require no other action than to seek the comments of the doctor concerned. The rôle of the unit would be merely to establish in a preliminary and neutral way the facts of the case. It would play no part in the preparation of a case against the doctor. Because we consider that points of difficulty could often be better elucidated by a personal interview than by an exchange of letters, we consider that the unit should, after giving appropriate notice, be able to arrange for a representative to discuss the issue first with the doctor and then with the other parties to the complaint. It would of course be wholly undesirable for the GMC representative to engage in random questioning of the doctor's patients. The doctor would be advised that he might wish to contact his defence society, and it would be open to him to have an adviser present at any interview or, of course, to refuse to be interviewed or to answer particular questions. We hope that members of the profession would not feel any inhibition about discussing the matters at issue with the unit's representative. To encourage ease of discussion, we recommend that the report of the interview with the doctor should be fully privileged; that is, anything said would be inadmissible as evidence in any formal hearing. At the conclusion of its investigation the unit would report to the President, clarifying the point at issue and setting out the evidence collected, but not drawing inferences from the facts nor recommending what further action, if any, should be taken. The President would then decide either that the matter be dismissed or alternatively that the matter should be taken further. By analogy with the proceedings of committing magistrates we think it right that the doctor, who has most to lose from the investigation, should have access to the information on which further consideration of the case is to be based. Thus a copy of the unit's report should be sent to the doctor whose registration might be brought into question and he would have the right of comment within a set time.

Matters relevant to complainants

(*a*) *The identity of the complainant*

260. We deal here with the particularly difficult problem of whether the source of a complaint should, in all circumstances, be revealed to the doctor concerned. As a general rule we would of course expect that all the information available to, or gathered by, the GMC which is pertinent to a charge of serious professional misconduct should be available to the doctor. It follows from this that we would normally expect the name of the complainant to be revealed. The GMC submitted the following evidence on the matter:

[1]As will emerge, we believe the President should supervise the early stages of fitness to practise action.

"The Council has taken the view that, if it were compelled to reveal to any respondent doctor the name of any person who had sent to the Council information regarding the activities of that doctor, whether or not that person was subsequently required to give evidence, this would inevitably discourage a large number of persons, both medical and lay, from bringing to the Council's notice matters which, on investigation, have subsequently been considered to raise a question of serious professional misconduct. This would not be in the interests of the public or of the profession".

With this judgment we concur with some reluctance. An analogy may be drawn with criminal proceedings. Here, where a prosecution is initiated, the accused person is not necessarily told who first brought to notice the matters with which the accused is charged, although frequently this will emerge when evidence is given against him. It is of course distasteful that a man's competence or probity should be called into question by information from unrevealed sources, but what matters at the end of the day is not who laid the evidence but whether the doctor has done what has been alleged. Before leaving this topic we mention a point which may otherwise lead to confusion. The possibility of a doctor not knowing the origin of the complaint arises only where the GMC initiates a case: for example, in respect of advertising where there might be no complaint from an outside source. Where a complainant chooses to act as such in the formal sense, his identity is, as required by the Rules of Procedure, revealed to the respondent doctor.

(*b*) *The position of persons reporting doctors to the GMC*

261. During the course of our work we have become conscious of the existence of fear of the possible legal consequences of reporting a doctor to the GMC—fear, that is, of the consequences for the person doing the reporting. In view of the existence of such fear, we feel it right to point out that it is a defence to a complaint of defamation that "the defamatory statement was made on an occasion of qualified privilege".[1] This is a compressed way of referring to the principle that: "the statement is protected if it is fairly made by a person in the discharge of some public or private duty, whether legal or moral, or in the conduct of his own affairs in matters where his interest is concerned".[2] The qualification is "fairly". If the defendant makes the statement for some indirect and wrong motive, he is said to be "malicious" and thus to lose the protection of the occasion. It is really a question of honesty of purpose. What we have said here is of general application: that is, it applies to ordinary members of the public and to doctors alike. In view of the store which we set by a doctor's colleagues taking action where the doctor's mental or physical condition appear to make it necessary, we recommend that the GMC should promulgate widely advice on the position of doctors who report colleagues. We suggest the following as a suitable form of words:

"A doctor who, honestly and without malice, reported a colleague whom he believed to be sick to the appropriate authority, would have a complete defence to an action for defamation, although of course there can be no immunity against being sued. He would have this defence even if the colleague were subsequently shown to be well".

[1]The traditional phrase used in pleading to raise this defence.
[2]Salmond on Torts; 16th Edn.; Page 167.

PART D: PROFESSIONAL CONDUCT

I: General

Acceptance of the present system of control of professional conduct

262. The evidence we have received has shown broad acceptance of the way in which professional misconduct has been dealt with by the GMC in the past. While we have received many suggestions for change, they have in the main been formulated on the assumption that the present system of controlling professional conduct requires amendment rather than reformation. The Medical Defence Union commented that the conduct function of the GMC, "has been well carried out and that the profession as a whole is satisfied". The Medical Protection Society told us, "It is our view that the existing machinery functions well and does not require any major changes of structure or procedure". The defence societies are particularly qualified to judge the conduct work of the GMC, but the views they express are echoed elsewhere. The Hospital Consultants and Specialists Association, for example, said: "It must be emphasized that the GMC has, for the most part, done a very difficult job well, particularly in respect of discipline". It is of course essential that the procedures appear fair to the profession.

263. We think it right to point out here that the GMC's procedures for dealing with misconduct have formed the model for those found in many countries abroad.

Criminal convictions and their significance in relation to professional conduct

264. It is sometimes suggested that doctors should be treated no differently from ordinary members of the public in respect of criminal convictions; that is, that they should be subject only to the penalties imposed by the criminal law, and that the fact of a criminal conviction should not be a concern of the GMC. The suggestion is given an aura of credibility by suggesting that the existing provisions of the medical legislation involve *double* punishment or *double* jeopardy—something which seems unfair and oppressive. Such a view seems to us to fail to take account of the responsibility of the medical profession to the public. Doctors, like all other citizens, are subject to the ordinary law of the land and must expect to be punished for breaking it. The offence of which they have been convicted may raise the separate question of whether, in the public interest, they should be allowed to continue to practise medicine. While the general welfare of the public is not at risk from an habitually drunken poet, it is from an habitually drunken doctor. A subsequent consideration by the GMC of a doctor's fitness to practise arising from a criminal offence does not retry the offence—indeed the medical legislation obliges the GMC to accept a court's findings of fact—but is concerned with whether the fact of the conviction shows that the doctor is unfit to treat the public. It may be noted that a similar scrutiny of convictions having a similar purpose is applied to other professions and groups, notably to many public servants and magistrates. We do not have any hesitation in recommending the continued inclusion in the medical legislation of the GMC's duty to consider criminal convictions of doctors with a view to determining whether such doctors should continue to be registered.

265. Somewhat similar considerations apply to the scrutiny by the GMC of findings adverse to a doctor under NHS procedures, although in this case the doctor is charged with serious professional misconduct and is entitled to defend himself against the charge. The NHS procedures are designed to safeguard the needs of the NHS; that is, they deal with doctors whose actions fall below the standard required by the NHS as a condition of employment. The GMC then considers the doctor's fitness to continue as a member of the profession in the light of the facts, if proved to the Disciplinary Committee's satisfaction, that led to action by the NHS.

The desirability of a code of conduct

266. A suggestion frequently put to us was that a code of conduct should be established for the medical profession. By "code of conduct" is generally meant a detailed definition of what constitutes misconduct, set out in subordinate legislation. Rather than being charged with serious professional misconduct, a doctor would be charged with breaching a particular section of the code. It is argued that such a code would be fairer to doctors, particularly as obviating ambiguity about what constituted professional misconduct.

267. There are several objections to attempting to define professional misconduct in this way. A code, particularly if entrenched in legislation, could not be revised easily, and certainly not without wide consultations. As a result, the GMC's ability to react quickly to changing circumstances would be considerably restricted. Then again it would have to be proved that an act fell within the letter of a particular section of the code. The result would be that some undoubted wrongdoers would escape through technicalities: there would be increased scope for legal argument about the framing of the charge, and this might well lead to the substance of the matter at issue, that is, whether the doctor was fit to practise, being obscured. In our view, the main aim of those advocating a code can be met equally well by the issue of the general guidance which we propose in the next paragraph. The present system, under which the GMC is the arbiter of professional conduct, combines the advantages of simplicity and flexibility. It is also supported within the profession. The British Medical Association told us in their evidence that, in 1973, "A Special Representative Meeting of the Association passed the following resolution: That 'serious professional misconduct' interpreted as disgraceful and dishonourable by a doctor's 'professional brethren of good repute and competency' should remain the basis of judgment by [the GMC]". This no doubt reflects what we have already indicated as vital: that it should be the responsibility of the medical profession, acting through the new GMC, to assert high professional standards in the interest of the public. We recommend, therefore, that the test of professional misconduct should continue to be that provided in the present medical legislation.

Guidelines on misconduct

268. We recommend the issue by the GMC of fuller *guidance* on professional misconduct than has been issued in the past. Guidance is helpful not only because it sets out what conduct is likely to lead to proceedings, but also because it helps define the general nature of professional misconduct. Furthermore, the issue of guidance would reduce confusion about the GMC's work

in this field; entitle the GMC to point out to a doctor that he should have been aware that particular action was regarded as misconduct; and provide a focus for debate of what is misconduct. An analogy may be drawn here with the advice contained for motorists in the Highway Code. The status of this is set out in the Road Traffic Act 1960 as follows:

> "A failure on the part of a person to observe a provision of the highway code shall not of itself render that person liable to criminal proceedings of any kind, but any such failure may in any proceedings . . . be relied upon by any party to the proceedings as tending to establish or to negative any liability which is in question in those proceedings".

We envisage GMC guidance on misconduct as having a similar purpose. The guidance need not, in our view, be provided for in legislation because the authority of the GMC itself will confer suitable status on it. Indeed it would be in many respects similar in status to the guidance the GMC periodically issues on medical education. In addition to general advice, we believe it would be helpful if the GMC published examples of particular cases to illustrate the guidance. We believe that the medical profession would find such a general advice on conduct and comment on particular cases most useful if it were published regularly in booklet form. In short, we are recommending the regular publication of a much fuller version of the part of the GMC's so called "blue booklet" which we reproduce in Appendix B. This should not prevent the GMC from commenting on new problems, or indicating a change of emphasis, between editions. We note that the GMC has used its Annual Report for 1973 in just the way we envisage to comment on the improper delegation of medical duties to unregistered persons, "covering", in the light of a particular case. The GMC has told us that it is considering in detail the desirability of giving the sort of guidance we recommend; and we welcome this.

269. We received complaints about the unwillingness of the GMC to give advice in particular circumstances on the avoidance of misconduct. This problem arises chiefly in relation to advertising, and we return to it in our discussion of that subject[1]. Here we wish to point out the general limitation on the GMC's freedom of action in this field, and we do so by quoting some evidence we received from Sir David Campbell[2]:

> "Any hesitation to express an opinion or reticence on the part of the Council or the President is due to their statutory position. They are the judges of professional conduct . . . and are bound to judge every case that comes before them on the facts of the case as presented in evidence. Neither . . . therefore . . . can possibly commit the Council in advance . . ."

We share the view that a judicial body cannot give advice before the event on how to avoid its attentions. The seriousness of a particular act must be for the GMC to decide in the light of the circumstances of the case. Particular advice would, in any case, very likely have to be qualified because an act which, on the face of it, appeared acceptable might amount to misconduct by reason of subsequently disclosed evidence concerning the underlying motives of the doctor, or the circumstances in which he did what he did. We recommend,

[1]In paragraph 281.

[2]President of the GMC 1949–1961.

therefore, that the GMC restrict itself to referring those seeking advice to its general guidelines, and to the appropriate professional organisations. This need not prevent informal contact between professional organisations and the GMC on matters of conduct; only that the GMC could not be associated officially with any advice which was subsequently given by, say, the British Medical Association to a doctor about a particular course of action, nor restricted in any action which it subsequently wished to take.

Two problems of professional conduct

270. We have commended the existing basic structure of control of professional conduct. Here we wish to say a little more about its working in relation to sexual misconduct and advertising. In doing so we stress again that we do not regard it as our task to prescribe rules for the medical profession, but rather to consider the structure of regulation. The GMC's attitude to sexual misconduct and to advertising is, however, generally the main point of argument about the present structure of control. We therefore feel a duty to comment on these matters and we believe that in doing so we can illustrate some generally applicable principles about the control of professional conduct.

271. We recognise that doctors' sexual behaviour, and even more their self-advertisement, is likely to be less of a danger to the public than doctors' negligence. Equally we recognise that the concern of the medical profession is with whether the medical legislation involves a fair and reasonable approach to depriving a doctor of his livelihood on account of misconduct, and it is, as we have said, in relation to sexual misconduct and advertising that most disquiet is expressed with GMC controls.

272. Where, in what follows, we have been obliged to put a sex to doctor and patient, we have supposed—for no other reason than convenience—a male doctor and female patient.

(*a*) *Sexual misconduct*

273. Where a doctor has been convicted of an offence against the ordinary law relating to sexual behaviour, that fact is reported to the GMC. It was suggested to us in oral evidence that the punishment of such doctors by the courts made it inappropriate for the GMC to take notice of the conviction. This application of what we have referred to[1] as the theory of double punishment has a little more credibility here than elsewhere. A doctor who indecently assaulted a patient might well be treated more harshly by the courts than any other person guilty of a similar offence, particularly if it appeared that the doctor had taken advantage of his professional position. The improved credibility of the double punishment theory is, however, very marginal. Were no action to be taken in relation to the registration of such a doctor—in future perhaps under powers relating to the registration of sick doctors—the doctor's patients could be at specific risk. Nor do we regard that as the most serious consequence, as we explain when we come to non-criminal sexual relations between doctor and patient.[2] We do not therefore have any doubt that the GMC should consider the fitness to practise of a doctor convicted of a sexual offence.

[1]See paragraph 264.

[2]See paragraph 275.

274. We shall not, in reaching such a conclusion, have run contrary to the views of any but a tiny minority of our readers. In now asserting that the GMC's concern with sexual conduct must extend further than that which is illegal, that it must indeed relate to any sexual relations between a doctor and his patient, we enter more contentious ground. As a preliminary to our argument, we point out that the criminal law may be said to provide a *minimum* standard of acceptable behaviour within the community. If, therefore, it is desired to establish *high* standards in a particular field, the standards authority will need to scrutinise a range of behaviour which, while not contravening the criminal law, falls short of the required high standard.

275. We believe there to be only one good reason for the GMC to expect high standards of sexual behaviour among doctors. The diagnosis of a patient's ills and the doctor's treatment of them depend on complete trust and uninhibited communication between doctor and patient: a very sensitive relationship. Indeed the patient will be worried, he may be in pain; he will be looking for comfort or alleviation. It will be quite ordinary for a patient to have to reveal personal facts of great delicacy or to express deep-rooted anxieties. The relationship would not be simplified or communication made easier were it to be regarded as acceptable for doctors to make sexual advances to patients. A patient might well be reluctant to reveal symptoms if exposed to the added complication of being a legitimate object of sexual attentions from doctors. Nor would any doctor's task be easier if he had to contend with patients having in mind that his actions might be irrelevant to his professional task. We expect assent to these propositions from the most militant advocates of sexual freedom: they take account both of some patients' distaste for such advances and other patients' dislike of not receiving them.

276. In short we believe that the GMC ought to take action against doctors whose behaviour is likely to damage the crucial relationship between doctors and patients. This of course means a GMC concerned with the maintenance of high standards of sexual behaviour among doctors.

277. The acceptance that the aim of the GMC in relation to sexual misconduct is the maintenance of the special relationship between doctors and patients should provide a sound basis for the consideration of individual cases. We have said that we believe that any sexual relations between doctor and patient may be the concern of the GMC: that covers a wide range of behaviour. At one end of such a range of behaviour is the doctor who anaesthetises a woman in order to have sexual intercourse with her without her consent: that is rape according to the law. At the other end of the scale is the doctor who meets someone on his list of patients on a social basis, and—perhaps unaware of the fact that she is a patient—forms a sexual relationship with her, equally desired by both sides. While we do not suggest that the aim we have proposed for the GMC will provide an easy standard against which to judge sexual conduct, it does we think provide a clearer criterion for action than exists at present.

278. The present advice of the GMC on sexual conduct is as follows:

> "The Council has always taken a serious view of a doctor who *abuses his professional position* in order to further an improper association or to commit adultery with a person with whom he stands in a professional relationship."

In referring to "abuse of professional position" with someone "with whom he stands in a professional relationship" the advice identifies correctly, if very loosely, the test applicable to any specific conduct. The test implied by these phrases matches our test of conduct prejudicial to the relationship of doctors with patients. A doctor who anaesthetises a patient preparatory to raping her abuses his professional position and harms the confidence of patients in doctors; a doctor who has an affair with someone on his panel whom he has never treated does neither.

279. While we believe the intention of the advice to be correct, the advice itself fails to communicate the essential concern of regulation in this field. By "a person with whom he stands in a professional relationship" we assume is meant "a patient", and we believe the GMC should say so. If "a patient" is not what is meant, fellow doctors, nurses, and members of other professions working in the health field must be included, and we see no reason why a doctor's lawful sexual conduct with persons in such groups should be a matter for the GMC. "Improper association" is completely vague, and the reference to "adultery" could be held to be discriminate against unmarried women. In our opinion neither the sex nor the marital status of the patient nor the subjective and pliable notion of propriety ought to weigh in the question of a doctor's sexual conduct. The true test, we reiterate, is whether his action diminishes the trust of patients in doctors, and we believe that it should be possible for the GMC to devise guidance which makes this quite clear.

(*b*) *Advertising*

280. By contrast with its advice on sexual conduct, the GMC's advice on advertising seemed to us to set down much more clearly the basic aim of regulation.

> "A doctor who was successful at achieving publicity might not in fact be the most appropriate doctor for a patient to consult. In extreme cases advertising might raise hopes of a cure which then proved illusory."

We found no evidence that anyone would wish to see medicine laid open to the entire range of commercial advertising devices. Those who recommended the abolition of the ban on advertising seem tacitly to have assumed that natural good taste would restrict members of the profession to the more moderate forms of the art. No suggestion was made as to who should be the arbiter of this good taste.

281. Although we commend the GMC's advice—which is reproduced in Appendix B—we nevertheless believe that there is substance in the many complaints that the GMC had failed to strike the right note in dealing with charges

of professional misconduct arising from advertising; seeming to condone the incidental advertisement of famous figures in the profession while acting with severity against the less influential. As always, however, such complaints considerably oversimplify the issues and understate the difficulties.

282. We had little trouble in identifying and approving the basic test, which is that advertisement for the purpose of gain or professional advancement should be held professional misconduct in a doctor, as it is in all the other learned professions. The difficulty lies in applying the general test to particular instances. By our test, there are two elements to the misconduct, both of which will need to be present before misconduct is established; first, an advertisement and secondly, a wrongful intent. Of these the latter will cause the greater difficulty, for example where the advertisement is incidental to some apparently legitimate activity such as contributing to publications or the mass media. We see no prospect of devising a rule which will infallibly separate the self-seeking practitioner from the rest. The line will be hard to draw in this as in other fields of human motivation; but that seems to us no excuse for not trying. A GMC reconstructed, as we recommend, to be properly representative of the profession must aim to achieve a more acceptable and even level of adjudication. Apart from this, we believe that, in consultation with the profession, the GMC might devise ground rules for the more common situations—for example, the identification of those contributing to medical columns in newspapers and magazines, and those appearing on radio or television.

(*c*) *Sex, advertising, and professional misconduct*

283. We draw three conclusions from our discussions of sexual misconduct and advertising. The first is that control of professional conduct must be firmly related to professional function: the GMC needs to establish high standards of sexual behaviour among doctors because doctors could not otherwise do their job so effectively. Similarly, The Law Society no doubt needs to establish high standards of financial probity among solicitors because otherwise solicitors would not be trusted with people's money. We believe the principle we have enunciated has general application to doctors' professional conduct.

284. The second is that the effective establishment of high standards of professional conduct among doctors depends on the GMC being clear about its aims and communicating those aims effectively. In our judgment the GMC has, in the past, failed in this respect; and it has in particular failed in relation to doctors' sexual conduct.

285. The third general conclusion is that the GMC's task in scrutinising professional conduct is a most difficult one. The examples of sexual conduct we gave are as crude as they are rare, and actual cases usually present themselves

in far subtler shades. The same is true of advertising and of other forms of misconduct. In these circumstances it is absolutely essential that the means of considering individual cases be effective, sensitive, and widely acceptable. And that brings us to procedure.

II: Procedure

286. The rest of this part deals with the GMC's procedure for dealing with professional misconduct. The diagram on the next page summarises our views on this procedure, and also on the procedure we believe that the GMC ought to introduce to deal with sick doctors. We stress that it is a crucial element in our thought that there should be a ready means of cross reference between the GMC's procedure for dealing with professional conduct and that for dealing with the sick doctor.

The sifting of allegations

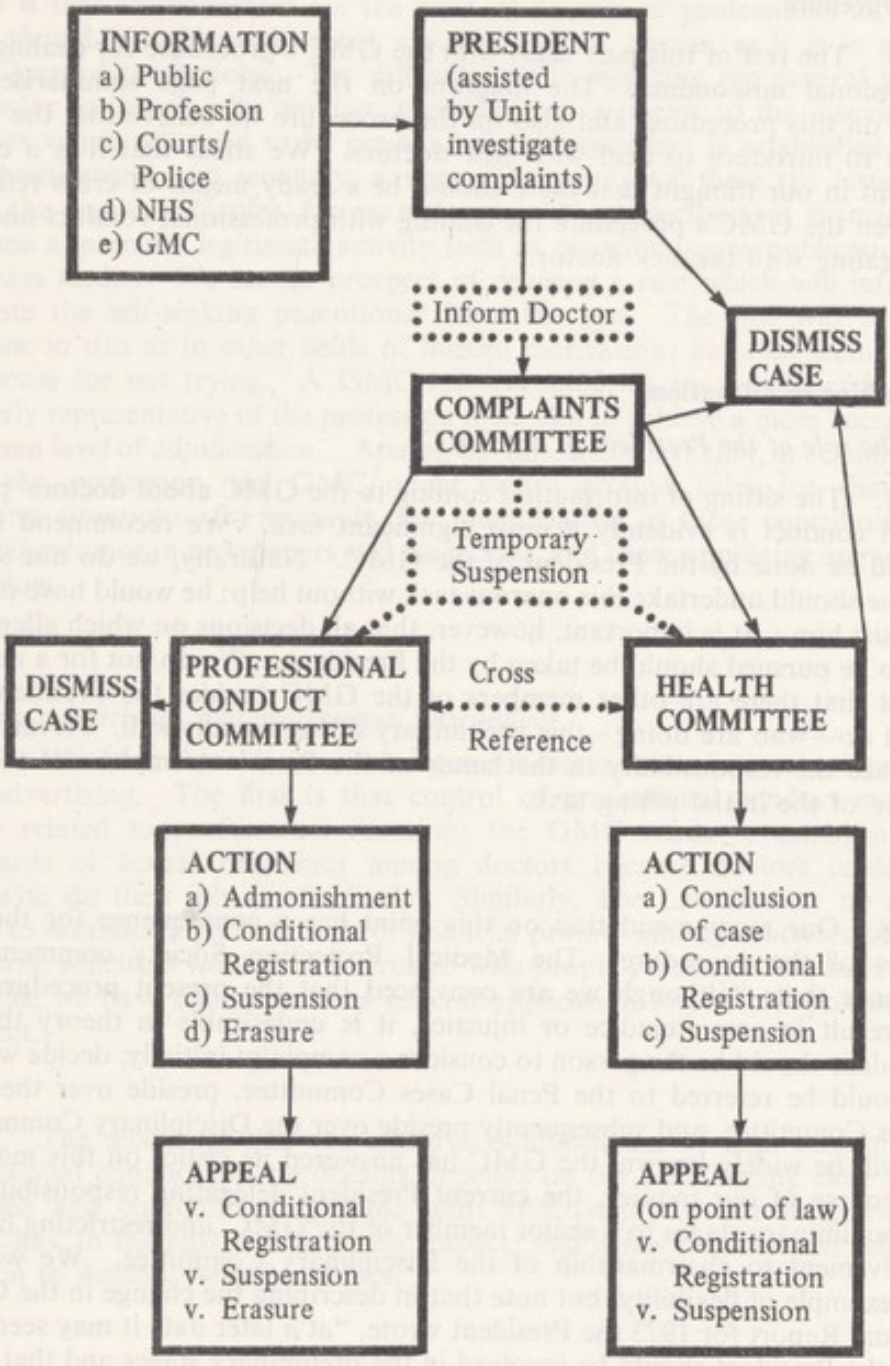
(a) The role of the President of the GMC

287. The sifting of information coming to the GMC about doctors' professional conduct is evidently a most significant task. We recommend that it should be done by the President of the GMC. Naturally, we do not suggest that he should undertake this onerous task without help: he would have officials to assist him. It is important, however, that all decisions on which allegations are to be pursued should be taken by the President. We do not for a moment doubt that there are other members of the GMC besides the President who could do—who are doing—this preliminary sifting equally well. Nevertheless, to place the responsibility in the hands of the President emphasises the vital nature of the initial sifting task.

288. Our recommendation on this point has a consequence for the later stages of the procedure. The Medical Protection Society commented in evidence that: "although we are convinced that the present procedure does not result in any prejudice or injustice, it is undesirable in theory that the President should be the person to consider a complaint initially, decide whether it should be referred to the Penal Cases Committee, preside over the Penal Cases Committee, and subsequently preside over the Disciplinary Committee." As will be widely known, the GMC has answered its critics on this matter in the course of our inquiry, the current President delegating responsibility for the preliminary stages to a senior member of the GMC, and restricting his own involvement to chairmanship of the Disciplinary Committee. We welcome this example of flexibility, but note that in describing the change in the GMC's Annual Report for 1973 the President wrote, "at a later date it may seem right that the President should be involved in the preliminary stages and that others should chair the Disciplinary Committee." This comment has anticipated our own view.

RECOMMENDED G M C

Fitness to Practise Procedures



289. The task of the President would of course be either to decide that no further action was necessary or alternatively to arrange for further clarification. As part of the process of further clarification, it might be necessary to make enquiries, and we have already suggested that such enquiries should be made through an investigating unit.[1]

(*b*) *A Complaints Committee: its functions*

290. We recommend the establishment of a Complaints Committee, the task of which would be to consider, on the information available, whether prima facie evidence had been assembled that a doctor was not fit to practise. We envisage this Committee as the final filter of complaints, and the replacement of the present—and unfortunately named—Penal Cases Committee. As such the Committee would not hold hearings but would either refer cases for further action or direct that the matter be closed, arranging for all interested parties to be informed in either case. It should meet sufficiently frequently to ensure that cases were dealt with quickly.

291. In describing the further action that might be taken, it is important to take account of the possibility that the doctor's behaviour might have been due to his ill-health. Where the Committee thought that a matter should be taken further, the Committee would refer those cases concerning misconduct to the Professional Conduct Committee, and those which turned on physical and mental illness to the Health Committee.[2] In most cases it would be clear which committee was appropriate, but we recognise that a problem would arise when the seriousness of a doctor's illness first became apparent through the commission of a particular act of misconduct or criminal offence. Where there was good reason to suppose that an act was a direct consequence of illness or where there was a reasonable element of doubt, we recommend that the appropriate solution would be for the case to be referred to the Health Committee. In the event of the Complaints Committee being found subsequently to have referred a case inappropriately, there should be means of cross reference between the Health and Professional Conduct Committees. Carefully handled, such cross reference ought not to give rise to difficulty.

292. We recommend a further, and particular, function for the Complaints Committee. We are in no doubt that in particularly disturbing cases the GMC ought to be able to order temporary—and of course provisional—suspension of a doctor's registration where there was clear evidence to suggest that his continued registration, for however short a time, would be a serious danger to the public. Under the Medical Act 1969 a power of immediate suspension at the conclusion of a hearing was granted to the Disciplinary Committee. We consider that such a power should also be available at an earlier stage. Consideration of a case by the GMC is inevitably a lengthy process and at present there is the risk that, before a hearing can be arranged, a doctor may continue to practise for an undesirable length of time to the potential detriment of his patients' interests and perhaps his own. A doctor is also in our view less likely to be subject to restraining influences from outside sources such as

[1]See paragraphs 256–258.

[2]See Part E for our description of the central machinery for dealing with the problem of the sick doctor.

his employers, colleagues, or legal advisers at the earlier stages of the proceedings than by the time his case reaches a hearing. We therefore recommend that a power of immediate suspension should rest with the Complaints Committee. We emphasise that the power should be used in only the most exceptional cases and should be temporary. We propose that a suspension should be for a defined period, not more than one month, and there should then have to be an emergency meeting of either the Health Committee or the Professional Conduct Committee to consider the case formally. If no meeting were arranged, the suspension order would lapse. Such a time limit would prevent unfair use of the power. Because the final decision on a doctor's registration would be taken in the normal way and because a suspension order would no doubt be made very rarely, we do not think that our recommendation would result in an unacceptable accretion of power to the Complaints Committee.

(*c*) *A Complaints Committee: its composition*

293. We recommend that the Complaints Committee should consist of the President of the GMC and 10 other members of the GMC, to include six members reaching the GMC by direct election, two members reaching the GMC by the nomination of an educational body, and two lay members reaching the GMC by Privy Council nomination. The quorum of the Complaints Committee, and the normal membership for dealing with cases, should, we believe, be the President—or a deputy chosen from the members of the Complaints Committee—and five of the members chosen proportionally from the constituent groups. The Complaints Committee in operation would therefore be the same size as the present Penal Cases Committee which, we believe, has worked well. It will be noted that we have entrusted the President with the oversight of all the preliminary stages of consideration of a case. We believe it to be desirable that the President's knowledge of a case should be available to the Complaints Committee in deciding whether a case ought to be referred for further action.

The practice of the GMC in sending doctors warning letters

294. The practice of sending warning letters is described by the GMC in its booklet on professional discipline as follows:

> "Not every conviction or allegation of professional misconduct necessitates an immediate reference to the Disciplinary Committee for formal enquiry although repeated offences may do so. It is the usual practice to send warning letters to a doctor who has been convicted for the first time of offences such as driving a motor car when under the influence of drink, or whose professional conduct appears to have fallen below the proper standards, in order that the doctor may reconsider his habits and conduct."

Apart from letters following conviction, warning letters are at present sent by the President where a properly constituted inquiry such as a hearing by a NHS authority has recorded an adverse judgment on the doctor's conduct[1] and by the Penal Cases Committee after consideration of the doctor's explanation

[1]This procedure has been modified recently in cases which originated from a NHS source to allow the doctor to comment before any decision is taken on a warning letter.

of his conduct.[1] We can appreciate the advantages of such a practice to the GMC. It provides the GMC with a flexible intermediate response to a case. A warning letter can make it clear to a doctor that, although the matter is not considered sufficiently serious for his registration to be brought into question at a further hearing, the GMC is in no doubt that his action is unworthy of the profession. Thus, the GMC told us, "It should be emphasised that the original intention of sending the communications which have come to be known as warning letters, was to enable a doctor's professional colleagues on the Council to give him an *informal* and private warning of the need to improve his standards of conduct". Such a letter can make the further point that repetition of the act might result in a formal hearing.

295. We consider that there are a number of objections to the warning letter. The sending of warning letters to doctors who have neither admitted their errors nor had the case against them formally established at a GMC hearing is undoubtedly resented by sections of the profession who further believe that the GMC has been inconsistent in their use. As a practical objection, it must be doubtful whether a warning letter is any more effective in persuading a doctor to mend his ways than knowledge that an allegation of unfitness has been formally considered by the GMC. We have said that the future GMC must be concerned with conduct meriting consideration of a doctor's registration. It is no part of the GMC's fitness to practise jurisdiction to comment on a lesser matter in the course of a particular case. More important, it seems to us wrong for a doctor to be in effect judged guilty—or at any rate half guilty—without a full right to be heard. We therefore recommend the discontinuance of warning letters. A dismissal letter should, in our view, merely state that a case of serious professional misconduct to answer has not been established. In cases of criminal conviction the GMC should inform the doctor that it had been notified of the offence but did not consider further action appropriate. We point out finally that it should be the purpose of the guidelines that we recommend to make clear to the profession what the GMC considers to be undesirable practices. These guidelines would be the place to make the general points that dismissal of a case does not necessarily imply approval of the conduct, and that repetition increases the seriousness of misconduct.

The consideration of allegations

(*a*) *the desirability of a "circumstantial letter"*

296. It has been suggested to us that the GMC should specify in a letter precisely with what misconduct a doctor is charged prior to any misconduct hearing. In support of such a letter, the British Medical Association commented that its purpose would be to set out "in narrative form the facts which [the GMC's solicitor] expects to prove in evidence against the accused and also the charges which arise out of these facts. The accused doctor would thus be fully aware in advance of the case against him".

[1]Rule 6(2) of the current Rules of Procedure states "Where the Penal Cases Committee determine that no inquiry shall be held in a case relating to conduct, the Registrar shall inform the practitioner and the complainant (if any) of the decision of that Committee in such terms respectively as that Committee may direct."

297. The advantage of a circumstantial letter depends—like so many other things—on what is meant by a circumstantial letter. A brief one might not represent much of a change from the present situation: the GMC has told us that the part deposition and part indictment produced before proceedings are instituted before the Disciplinary Committee of The Law Society and to which the British Medical Association referred, does not give a great deal of detail. The GMC has also told us that its solicitors "have pointed out that if this requirement were introduced the present interval between meetings of the Penal Cases Committee and those of the Disciplinary Committee (six or seven weeks) would have to be substantially extended." We wondered whether this was not trying to have it both ways.

298. For our part we recommend greater openness. The GMC said that it saw no objection to the provision, within certain time limits before a hearing of further and better particulars of the charge or charges. The evidence continued as follows:—

> ". . . further and better particulars would include such further details of the facts alleged in the charge as the respondent practitioner may need to know in order to identify with certainty all the events, acts or omissions to which the charge relates. The further information . . . would vary according to the nature of the charge; but it would not include the names and addresses of all the witnesses to be called by those presenting a case, or details of the evidence to be given by those witnesses."

We have said in our discussion of a GMC investigation unit that the doctor should have knowledge of the relevant material on which the Complaints Committee had considered the case.[1] We recommend that the doctor should also receive copies of any further material correspondence or statements to which the GMC's solicitor intended to refer explicitly in the hearing. In particular, we see no good reason why the doctor should not receive a list of all witnesses due to appear at the hearing with the details of their evidence. In our view an open procedure on these lines obviates the need for a circumstantial letter.

(*b*) *A Professional Conduct Committee*

299. We recommend the establishment of a Professional Conduct Committee, the task of which would be to consider doctors' criminal convictions and allegations against doctors of serious professional misconduct. We envisage this Committee would replace—but operate on the same judicial basis as—the present Disciplinary Committee.

300. In particular we do not recommend the introduction of some sort of jury system for conduct proceedings. An attempt to make an analogy here with the work of juries in Court cases is misconceived. Juries in criminal proceedings are operating in a quite different context from the work of the GMC and are subject to direction on the points at issue in a way that could not be applied to juries of doctors considering professional matters. We consider that the aim of the jury system, which after all is to ensure judgment by peers, is met equally well, and a good deal more simply, by the fitness to practise committees we recommend.

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[1]See paragraph 257.

(*c*) *The composition of the Professional Conduct Committee*

301. We recommend that the Professional Conduct Committee should consist of a chairman and 18 other members of the GMC to include 12 members reaching the GMC by direct election, four members reaching the GMC by the nomination of an educational body, and two lay members reaching the GMC by Privy Council nomination. The quorum of the Professional Conduct Committee, and the normal membership for dealing with cases, should consist of the Chairman, or a deputy, and nine of the committee chosen proportionally from its members. The dominant position we recommend on this committee for elected members of the GMC is, in our view, very important: the judgment of professional conduct ought, we believe, to rest principally with the representatives of the ordinary practising members of the profession.

302. It is sometimes suggested that the chairman of the GMC committee dealing with misconduct should be legally qualified. Arguing against the desirability of a legally qualified chairman the Medical Protection Society pointed out that "serious professional misconduct remains essentially a question of professional ethics rather than of law . . . a Chairman who is himself a member of the profession must surely have a much more reliable sense and feeling of the written and unwritten rules governing the profession than a lawyer". We concur with this view. In addition, we stress the importance of the role played by the Legal Assessor. Under the medical legislation the GMC is required to appoint an experienced lawyer[1] to advise the Disciplinary Committee on questions of law arising in its proceedings. We believe this device to work well and recommend that the present system, under which the chairman of the committee considering allegations of misconduct (at present the President of the GMC) is advised in proceedings by a legal assessor, should continue.

(*d*) *The procedure of the Professional Conduct Committee*

303. In deciding our general approach to the procedure of the Professional Conduct Committee we noted comments that the hearings of the present Disciplinary Committee are conducted in an over-legalistic manner and that there would be advantage in greater informality. We consider that there may have been a misunderstanding about both the nature and the details of the proceedings. Because his livelihood is at stake, it is an extremely serious matter for a doctor to appear before a Disciplinary Committee hearing. We believe that there must be a reasonable measure of formality at the hearing to ensure that the case is conducted fairly. Indeed, who would wish to be deprived of his livelihood informally? It is in any case highly unlikely that the profession would wish to waive its general right to legal representation. We further comment that a close reading of those Rules of Procedure which set out in detail the way in which a Disciplinary Committee hearing is to be conducted removes much of the grounds for criticism. Because the Rules have the status of subordinate legislation—and it would in our view be undesirable for the procedures to be at the discretion of the GMC—they are of necessity couched in legal terms. In essence, however, they simply ensure that all parties are given every opportunity to put their case and, in particular,

[1]He must be "a barrister, advocate or solicitor of not less than ten years' standing".

that the doctor who is the person with most to lose is able to challenge at every stage the evidence against him. The Rules relating to a Disciplinary Committee hearing seemed to us reasonable and we recommend that those which succeed them should be similar.

304. We mention here one matter which caused considerable concern in the past. This was the alleged lack of sensitivity to the position of the doctor at the hearing. In particular, we were told that it was quite unnecessary to place the doctor in a "dock". We mention this simply to record that the GMC has recently dispensed with the dock. This is a change we heartily welcome. The tables for a hearing are now arranged in an oval formation with the doctor seated at a normal table next to his legal adviser.

(*e*) *Should decisions of the Professional Conduct Committee require a two-thirds majority?*

305. Under the medical legislation the Disciplinary Committee needs only a simple majority of its members to reach a decision on the matters before it, and it was put to us by a number of organisations that this did not provide adequate protection for the doctor. For example, the British Medical Association commented, "decisions of [the Association's proposed replacement of the Disciplinary Committee] should require at least a two-thirds majority to be effective". We asked the GMC for its comments on this proposal and were told, "In the opinion of the Council no injustice to any doctor has occurred from the existing arrangements, and the Council would not wish itself to initiate any change." The GMC further pointed out that the procedures must strike a balance between protection of the interests of the doctor appearing before the Professional Conduct Committee and of the public liable to be harmed by unfit doctors. We agree with the GMC that the present procedures afford substantial and proper safeguards to doctors and, since we have received no evidence to suggest that injustice has occurred to any individual practitioner as a result of the voting arrangements, we see no reason to recommend any change in the present position. We therefore recommend that decisions of the Professional Conduct Committee should be by a simple majority of its members.

Action by the Professional Conduct Committee, and afterwards

(*a*) *Sanctions*

306. We recommend that the sanctions available to the GMC should continue to be related to its power to control the registration that by law affords the doctor the right to practise in any capacity: that is, under our recommendations, general registration. Any power, for example, to levy fines or require a doctor to contribute to the cost of the proceedings would add to the GMC's procedures an atmosphere of punishment which would, in our view, be wholly inappropriate.

307. We do recommend that the Professional Conduct Committee should have more flexible powers than does the Disciplinary Committee at present. We propose first, that the Committee should be able, as is the Disciplinary Committee now, to *admonish* the doctor. Secondly, we recommend the Committee should have the power to impose *conditional registration.* This is

our major proposal for innovation in this field. Conditional registration would be for a fixed but renewable period and would be applied in cases where it was considered that the doctor should not be deprived of his livelihood but where it was appropriate for the GMC to have greater means of supervising his future actions than is possible at present. Conditional registration is relevant to professional misconduct—and, in particular, as embracing conditions such as having to report back to the GMC, would obviate the need for the present power to postpone judgment—but is more significant in relation to the sick doctor. We therefore discuss this proposal more fully later.[1] The Professional Conduct Committee should also, we recommend, be able to *suspend general registration.* This would be used in the same way as the existing power; that is, the Committee would order that the doctor's registration should cease to have effect for a period not exceeding 12 months, the suspension being subject to renewal. In future at the expiry of a period of suspension, the Professional Conduct Committee should be able, as an alternative to renewing a period of suspension or concluding the case, to order a period of conditional registration. Finally, we recommend that the Committee should have power to *erase a doctor's name from the Register.* We do not, so far as this sanction is concerned, propose any change in existing practice.

308. We recommend that an order of the Professional Conduct Committee should take effect on the expiry of the time within which notice of appeal may be given. We recommend also that the Professional Conduct Committee should have the power to order the immediate suspension of a doctor's registration where otherwise there might be danger to the public. The present Disciplinary Committee has such a power,[3] and it will be recalled that we have recommended a similar power for the Complaints Committee.[2] Apart from the main argument of safeguarding the public interest, it would obviously be anomalous if, after a hearing of the Professional Conduct Committee, there were to be a short period when a doctor who was a danger to the public was allowed to practise without hindrance.

(*b*) *Reasoned decisions*

309. It has been put to us that the Disciplinary Committee or, as we recommend, the Professional Conduct Committee should give reasons for its decisions. The Medical Defence Union argued that "the respondent practitioner, the profession and the public should know why the practitioner has been acquitted or been found guilty of serious professional misconduct". We regard reasoned decisions, where the case against the doctor was dismissed, as wholly undesirable since the result would be to introduce grades of acquittal. As an example of what might happen, a doctor would no doubt be happy to be sent from the hearing "without a stain on his character", but less so if he was acquitted on a technicality. A doctor who had been acquitted in a way that cast doubt on his truthfulness or good faith might well feel aggrieved at the outcome. We do not therefore recommend a reasoned decision in cases of acquittal. As regards a reasoned decision in cases where serious professional misconduct had been found or where a registration sanction had been imposed,

[1]See paragraph 345.

[2]Under Section 15 of the Medical Act 1969.

[3]See paragraph 292.

we understand that the question of appeals was an important factor in the support given to the proposal by the British Medical Association and the defence societies. It was argued that a reasoned decision would assist the practitioner and his advisers in deciding whether there were good grounds for appeal. The Judicial Committee of the Privy Council have also commented, in their judgment in two cases where there was strong conflict of evidence, that a brief statement of the reasons for the Disciplinary Committee's actions would have been helpful. The GMC's comments on the matter were as follows:

> "In deciding which facts are proved the Disciplinary Committee assumes a function equivalent to a jury; and no jury is required to state the grounds for its verdict. The reasons are not difficult to see: different members of the jury, or of the Disciplinary Committee, may attach different degrees of weight to different pieces of the evidence; and a minority of the jury or Disciplinary Committee may indeed not agree with the verdict of the majority. It is convenient for all concerned that the decisions of the Disciplinary Committee should be announced at the conclusion of each case, but to give reasons for those decisions in terms acceptable to the whole Committee at that time would be very difficult. Nor would to do so at a later date, after the members of the Committee had dispersed, be much easier. In practice it would probably be necessary to invoke the assistance of the Legal Assessor and to hope that the members of the Committee would be prepared to subscribe to his interpretation of their reasons; but whether this course would be realistic is open to doubt."

310. For our part, in addition to the comments of the GMC above, we stress that one of the strengths of the Professional Conduct Committee on the lines we recommend is that the accused doctor would receive from it a judgment which, as a result of the Committee's membership, largely derived from his professional colleagues; that is, from a "jury" of his peers. As the GMC comments, juries do not give reasons for their verdicts. Since we doubt whether a formal reasoned decision could be given satisfactorily in all cases *at the end of a hearing*, we are not convinced that it should be given at all. The likely result of any attempt to link the formal giving of reasons with the likelihood of appeal would probably be to prompt every practitioner to suggest that he was planning to appeal. Finally, reasoned decisions might have the regrettable effect of emphasizing the legal aspects of a case to the point where matters were judged primarily on points of law rather than on the substance of the issue; that is whether the doctor is fit to practise. We do not therefore recommend reasoned decisions in those cases where doctors are found to have committed serious professional misconduct.

311. In making such a recommendation, we are not seeking to suggest that the Chairman of the Professional Conduct Committee ought not to express the views of the Committee when announcing the Committee's decision on a case. At present the Rules of Procedure provide, in relation to the Disciplinary Committee, that "The Chairman shall announce the determination . . . of the Committee . . . in such terms as the Committee may approve". We infer this provision to be designed to enable the expression of views—sympathetic or condemnatory—in the fashion practised by the courts. So long as it is not overdone, we see nothing objectionable in this practice.

(*c*) *Appeal rights*

312. The position in relation to appealing against the decisions of the GMC's Disciplinary Committee is that the doctor has a right of appeal against an order by the Committee that his registration be erased or suspended. The doctor has no right of appeal against a finding by the Disciplinary Committee that he is guilty of serious professional misconduct, unaccompanied by an order for suspension or erasure. The medical legislation confers no appeal rights on complainants.

313. The *first* question we wish to consider is whether the medical legislation ought to confer a right of appeal against that finding on all doctors found to have committed serious professional misconduct, irrespective of whether a registration sanction was imposed. The case for such a right is that to be found to have committed serious professional misconduct is a great disgrace, whether or not any sanction follows, and that the doctor ought to be allowed access to the superior courts of justice to seek the overturning of such a finding. We have a good deal of sympathy with the feelings behind such a view. We believe, however, that it rests on a lack of understanding of the existing means of judging professional misconduct. As we have pointed out, the courts have been reluctant to interfere with the view of the GMC, the view they rightly take to embody that of the medical profession, of what constitutes misconduct in the medical profession. This point is an important one, and we think it right to illuminate it crudely and simplistically—why should lawyers settle doctors' professional standards? The consequence is that we doubt the significance of an appeal right to the courts, *as a fresh arbitrament of professional standards*, in any case—even those where a registration sanction is imposed.

314. Naturally the courts suffer from no such inhibition as we have described over scrutinising judgments of the GMC to see whether they were reached fairly and properly. The judgments of the GMC which involve registration sanctions will affect, immediately and directly, the doctor's livelihood. We believe that in these circumstances a right of access to the courts is much more relevant. The fact that the GMC's decision will directly and immediately affect the doctor's livelihood increases the importance of that decision having been reached fairly and properly.

315. We therefore recommend that there be a right of appeal against a direction of the Professional Conduct Committee that the doctor's registration be suspended or erased, as at present, and also against an order of conditional registration since that might entail major limitations on the doctor's livelihood.

316. We believe the arguments for limiting the right of appeal as at present are finely balanced. Unless, however, over the workaday GMC, there is set up some sort of superior GMC with the task of reviewing the former's decisions, there seems no point in widening the ambit of responsibility for the judgment of professional misconduct.

317. The *second* question with which we wish to deal is to which court appeals should go. The present right of appeal is to the Judicial Committee of the Privy Council. It was variously suggested to us that the right of appeal should be rather to the Court of Appeal or the House of Lords. We have no hesitation in rejecting the suggestion that the right of appeal should be to the Court of Appeal. If it were, the consequence, in the absence of special provision, would be to allow a right of appeal in turn to the House of Lords. We have explained our objection to widening responsibility for the judgment of professional conduct, and it follows that we see no case for a double-tier right of appeal. It had been suggested to us that an appeal to the Privy Council might be more costly than an appeal to the Court of Appeal but we could discover no evidence that this was necessarily so. In any case, doctors wishing to appeal would probably be assisted by a defence society, and certainly it would reflect great discredit on a society to refuse to appeal purely because of the expense.

318. The suggestion that the right of appeal should be to the House of Lords rather than to the Judicial Committee of the Privy Council is, we believe, based on a misapprehension concerning the relative standing of the Judicial Committee of the Privy Council and the House of Lords. An appeal to the Judicial Committee is not an appeal to a special body, but an appeal to one of the two highest courts in the land. We understand that the reason for the appeal being to the Judicial Committee rather than to the House of Lords is to avoid any difficulty over appeals from doctors in dependencies not constitutionally part of the United Kingdom, such as the Channel Islands, or the Isle of Man. There is no jurisdictional difficulty in the Judicial Committee over appeals from these places. In these circumstances we do not hesitate to recommend that the right of appeal against decisions of the Professional Conduct Committee should continue to be to the Judicial Committee of the Privy Council.

319. The *third* and final question is whether some sort of appeal right should be conferred on complainants. There seem to us to be two main arguments in favour of conferring such a right. The first is that the GMC may reject a complaint now—and would be able to do so under our proposals—without holding a hearing. It is arguable that the courts ought to be able to order a hearing either before themselves or directing the GMC to do so. Secondly, the GMC's judgment of a case may occasionally turn on the credibility of the complainant, so that the GMC decision in effect brands him or her a liar. Our view is that the nature of fitness to practise proceedings rules out a right of appeal for complainants. The aim of the GMC's fitness to practise controls is to protect the general public, not to provide for some sort of adversarial consideration of the merits of two opposing points of view; and the civil courts, not the GMC, are the places for an individual to seek personal redress against a doctor. If the GMC is satisfied at any stage that the matter brought before it does not raise a question of fitness to practise, there seems no good reason for the exercise of its discretion in any particular case to be brought into question by an individual member of the public who, unlike the doctor, is not at immediate risk of losing his livelihood.

(d) Application for restoration to the Register

320. We see no reason to recommend any change in the present arrangements[1] for considering an application for restoration to the register, or removal of other limitations on registration, other than their extension to cover the imposition of the conditional registration which we have proposed.[2] As happens now, the GMC, before reversing or modifying an order, would no doubt wish to be satisfied that there was little likelihood of a recurrence of the behaviour leading to action against the doctor's registration.

Conduct proceedings and publicity

321. At present, Disciplinary Committee hearings are in public, but the Committee reaches its decisions in private. The hearing may very occasionally be in camera if matters of delicacy are involved. There are no restrictions on press reporting of proceedings, although in practice the press respects a request from the Disciplinary Committee Chairman that the anonymity of a party to the proceedings be preserved.

322. The very strong feelings that exist over the press reporting of GMC misconduct proceedings came out in evidence to us. The following comment, from a doctor who explained that he devoted three-quarters of his time to medical journalism, was typical.

> "To subject a man to a week of headlines like '*Sex on the Surgery Couch*' is to punish him. The fact that he may be found not guilty at the week's end does not erase the headline from people's memories."

Apart from arguments such as this about the unfairness of press reporting, two other arguments were put to us. It was suggested that press reports of misconduct proceedings have led both the profession and the public to think that the GMC is pursuing sexual matters to the exclusion of other and perhaps more serious failings. With this we wholly agree, though it is not of course fair to put all the blame on the press: some responsibility is shared by the GMC for not publicising its work adequately. Secondly, as the Medical Protection Society told us, ". . . publicity may also cause distress to innocent witnesses and deter would-be complaints from reporting their genuine grievances to the GMC". On the other hand the classic—and powerful—argument was put to us that the aim of GMC misconduct proceedings is to protect the public and that it is the price of public confidence in those proceedings that they should be openly reported. The practical suggestions put forward in evidence reflected these views, and ran from suggestion of the introduction of almost complete secrecy of proceedings, to leaving things as they are.

323. We recommend a middle way, which we believe combines a proper respect for the feelings of those involved in misconduct proceedings with maintenance of the public right to be informed of matters of public concern. The main change we propose is that legislation should be introduced to prevent the reporting of allegations of serious professional misconduct unless

[1]See Appendix C paragraph 32.

[2]See paragraph 307.

those allegations are proved. In more detail our proposals are as follows. *First*, we do not recommend any change in the existing practice relating to the admission of the public to proceedings. The Professional Conduct Committee's discussion of a case must obviously take place in private, but only very rarely indeed, we believe, should the public be excluded from hearings—particularly if our main proposal for change is accepted. *Secondly*, we do not recommend any change in the present practice governing press reporting of misconduct proceedings where those proceedings are taking place because of a criminal conviction—it would seem to us artificial to attempt to place restrictions on the reporting of proceedings dealing with court cases which will have been freely reported. *Thirdly*, we recommend that press reporting of hearings of allegations of serious professional misconduct should be banned until the completion of the hearing, so that the press could not report any such hearing until its outcome was known. *Fourthly*, we recommend—and it is our most important recommendation in this field—that press reporting of a hearing not resulting in a finding of serious professional misconduct should be banned. The lifting of this ban should, we recommend, be possible only through the exercise of a discretion conferred by the legislation on the Chairman of the Professional Conduct Committee. We would expect such a discretion to be exercised so that a doctor who was found not to have committed serious professional misconduct could apply to have the hearing reported. Such a request would be granted so long as the Chairman saw no reason—in particular the exposure of a witness to publicity having a cruel effect—to refuse. We point out that where a doctor was found to have committed serious professional misconduct, the press would be able—when the outcome was known, but not before—to report the proceedings with the same freedom as at present. *Fifthly*, we recommend that these proposals be given the effectiveness that comes from legislation, and that the legislation should contain sanctions to ensure that it is observed. We mention finally that if our proposals are implemented, the GMC will need to review its practices in relation to the maintenance and publication of its official records.

324. In the closing stages of our deliberations, the GMC brought to our attention a particular problem which occasionally arises. This is that public comment is made in the Press or elsewhere on particular allegations of misconduct which are about to be considered, either at a hearing or at some earlier stage of the procedure, by the GMC. The GMC pointed out that it was required to approach such allegations in a judicial spirit; that for the allegations to become the subject of public controversy was highly undesirable; but that the GMC lacked the power enjoyed by the ordinary courts to insist on the absence of public comment on a case which was still sub judice.

325. We share the GMC's view that public comment on an allegation of misconduct prior to its determination is wholly undesirable. In a society governed by the rule of law it is the essence of judicial proceedings that they should not have been subjected to outside influences nor have appeared to be so influenced. The innocent have as much of a stake in this matter as the guilty: what innocent person wants to have it said that he was let off because of public clamour rather than because he was innocent?

326. We therefore believe that *once the GMC has initiated proceedings* the ban to which we have referred above[1] should come into force to prevent public comment. We stress "once the GMC has initiated proceedings" because nobody of course would wish to inhibit the sort of press investigation *which might lead to* the initiation of proceedings.

327. We mention here one matter of detail on public access to the work of the Professional Conduct Committee. Prompted by evidence from a member of the public, we asked the GMC about the practice of refusing access to transcripts of proceedings before the Disciplinary Committee to persons who were not parties to those proceedings. The GMC replied that its legal advice was that the present Rules of Procedure implied that such persons were not entitled to transcripts. The GMC said that it would be unlikely to object to a change in this matter if this were generally considered desirable, particularly since the courts[2] now allowed anyone to have copies of transcripts if they paid for them. A change in the Rules to allow greater opportunity of access to transcripts would help increase the openness of the proceedings and to that extent be in the public interest. Our recommendation on publicity would, however, prevent access where the case was dismissed.

PART E: THE SICK DOCTOR

The evidence of sick doctors

328. Nobody who had seen the detailed evidence presented to us would underestimate the nature and scale of the problem of the sick doctor. We have, in particular, received details of cases from the Department of Health and Social Security, from the GMC, and—indirectly but with their permission—from the British Medical Association. Unfortunately the full force of the evidence cannot be conveyed in this report. For obvious reasons we have tried to avoid any particulars which might allow the doctors concerned to be identified, and this has greatly lessened the impact of the individual cases. It is so frequently the details which bring to life what is involved: the doctor whose appearance at a locum bureau always frightened the clerical staff; the doctor who believed that his practice of a form of sexual perversion on patients was beneficial to their particular condition; and the doctor who was sure the electricity supply was being systematically contaminated. A particularly horrifying feature of the evidence was the length of time such doctors continued in practice: we received details of chronic alcoholics who had been known to be such for 20 years and more.

329. Here are some representative cases. Between 1938 and 1960, *Dr A* was convicted several times for drunkenness and fraud, and was imprisoned more than once. Although he appeared before the GMC on a number of occasions his name was never erased. In the nineteen-sixties he was convicted of fresh offences and it became evident that he was—and had been for a very long time—addicted to both alcohol and drugs. *Dr B* came to the GMC's notice for a homosexual assault on a young boy. He was also an alcoholic and it appeared that he could avoid criminal homosexual behaviour so long as

[1]In paragraph 323.

[2]Except the Divorce Courts where permission has to be obtained.

he kept off alcohol. His name was erased from the Register for the criminal homosexual act but subsequently restored on evidence of treatment for alcoholism—but the GMC had no means to do anything about removing his name when he relapsed into alcoholism until he committed a fresh homosexual offence. *Dr C* was a locum who piled all the drugs in the surgery into a bucket which he then put in the surgery waiting room, with a label requesting patients to help themselves and not bother him. When taxed with this by the GMC, Dr C said his method of treatment was no more random than that of other doctors. *Dr D* suffered from a cerebro-vascular disease and was reported to be "vague, disinterested, and slow in thought and reaction" for four years before he could be persuaded to resign his general practice which covered a large council estate. *Dr E* was addicted to drugs. After drug irregularities in the hospital in which he worked, he was suspended from duty, but subsequently was found to be applying for hospital posts in a different region. Dr E was later prosecuted by the police for drug offences and only after that did his name come to the attention of the GMC. *Dr F* was a surgeon who continued to practise despite displaying the symptoms of a progressive disabling disease, and took part in two operations where serious harm to patients occurred.

330. In the nature of things there are no reliable statistics which would enable us to make, with any confidence, an estimate of the size of the problem. But it is clear from the evidence we received that it is not small. So far as the distribution of such cases is concerned, particular areas of risk appear to be single handed practitioners and doctors supporting themselves through regular locum appointments. On the nature of the cases some evidence we received from the GMC is of interest.

> "The cases involved psychiatric illness of varying kinds, but certain categories can be distinguished. The largest category arose from an addiction by the doctor to alcohol or drugs which was associated with and accentuated the results of some other concurrent personality disorder. In another category of cases the doctor's mental capacity had deteriorated, presumably as a result of brain disease: these cases included some of pre-senile dementia. A third category consisted of cases in which the charge concerned irresponsible and anti-social behaviour, such as a sexual offence or some kind of dishonesty, and the doctor's conduct was said to have resulted from a form of psychiatric illness."

331. We conclude this sub-section by quoting the comment of the GMC on the evidence it had amassed on psychiatrically ill doctors:

> "Usually the doctor himself is the chief sufferer and his illness is frequently prolonged through his refusal to seek treatment. The existence of psychiatric illness in a doctor can also impose a great strain upon his colleagues and those associated with him in his practice. Some harm has resulted to patients from the existence of psychiatric illness in a doctor, although the evidence does not suggest that this has often occurred. Clearly, however, the incapacity of a doctor with a psychiatric illness is hazardous to his patients insofar as it may prevent him from attending them at times when medical care is urgently needed, or disturb his judgment of their condition."

That seems to us to be an eminently fair and sensible comment.

A role for the GMC in relation to the sick doctor

332. The need for the GMC to have power to control the right to practise of sick doctors is so overwhelming and so obvious that it seems to us amazing that the GMC has continued for so long without such a power. There *are* very sick doctors, and by no means all of them have enough insight into their condition to retire from practice before they endanger their patients. Those who do continue to practise can be completely stopped from doing so only if they commit a criminal offence or do something which constitutes serious professional misconduct. That is not a rational way of ordering matters.

333. To those who might urge that the NHS machinery for dealing with sick doctors is sufficient we put three points. *First*—and most significant—the NHS machinery is very unco-ordinated. There is no means of comprehensively preventing the employment of an individual practitioner throughout the NHS. There is only an informal means of comprehensively preventing the employment of an individual practitioner within the NHS hospital services. There is a means—very rarely resorted to indeed—of comprehensively preventing the employment, as a principal in general practice, of an individual practitioner. These arrangements are separate to a greater or less extent, for each of the countries in the United Kingdom. *Secondly*, the procedures for dealing with emergencies—the procedure under paragraphs 40–42 of the terms of service for general practitioners, and the so-called "three wise men procedure" for hospital doctors—are we believe insufficiently effective. In particular they are not widely enough understood, and require considerable replanning by the NHS authorities. *Thirdly*, NHS procedures naturally do not apply to the private sector of medicine.

334. Since there is a sick doctor problem and the existing NHS controls cannot cope with it, the alternatives are either to improve the NHS controls or introduce GMC controls. We prefer the latter for two reasons. First, we believe that the question of a doctor's general fitness to practise is more appropriate to the GMC than to the NHS, although plainly the NHS has a serious responsibility for the health of those providing, under the NHS, medical services to the public. Secondly, control through registration will provide a universally applicable control; that is, to all parts of the NHS and to the private sector. [1]

335. The GMC has recognised the need for machinery to deal with the mentally sick doctor and has carried to an advanced stage the planning of a role in this field. Furthermore, and we regard this as very significant, it has done so with the broad encouragement of the rest of the profession.

Mental and physical illness to be covered

336. We concur with the opinion of the Medical Protection Society who told us "the Society reiterates the view already expressed to the General Medical Council that there is no good reason why [a procedure for dealing with sick doctors] should be restricted to mentally sick doctors and that it could be used when the physical incapacity of a doctor presents a hazard to his patients."

[1]And for that matter in the European Community.

While physical illness will not usually be dangerous to patients unless the doctor does not or will not appreciate the limitations that his condition imposes on his fitness to practise, we think it preferable that there should be no doubt about the scope of the GMC's power to consider cases of illness. We also stress that included in mental and physical illness should be addiction either to drugs or to anaesthetic gases and also undue dependence on alcohol.

The local machinery

337. In its evidence to us, the GMC proposed a two tier procedure for the control of doctors unfit to practise through illness. In summary, the GMC suggested that initial consideration of a case should be carried out by local panels whose power would depend on persuasion. Where the case was not concluded satisfactorily at a local level there would be a central machinery consisting of a separate committee of the GMC to which would be reserved the power to order any formal limitation of a doctor's registration. We return to the central machinery later.[1] Here we wish to deal with the important issue of the desirability and role of *local* machinery.

338. The GMC described in detail its proposed local machinery in the following evidence.

> "At the local level panels of examining doctors would be appointed by the Council in each National Health Service region. The panels would be composed of psychiatrists, neurologists, physicians and general practitioners nominated by the appropriate professional organisations. After consultation the Council would also appoint a doctor to act as Chairman of each panel.
>
> It would be open to any member of the profession who had evidence suggesting that another doctor was suffering from psychiatric illness to approach either the Chairman of the regional panel or the Council. Where the Chairman of a regional panel received evidence which suggested that a doctor was suffering from psychiatric illness it would be open to the Chairman, after making such enquiries as he thought fit, to invite the doctor to submit if necessary to medical examination in his own region. The Chairman of regional panels would exercise care to avoid unnecessary action on trivial or unsubstantiated grounds. Where the case was initially notified direct to a Chairman of a regional panel, he would act at his own discretion without prior reference to the Council; and the Council envisages that most cases would in fact be dealt with in this way. Where however information of a suspected case was first received by the Council, the President or some other member of the Council authorised for the purpose (or in certain circumstances . . . the Penal Cases Committee or the Disciplinary Committee) would refer it to the Chairman of the regional panel. Special arrangements might be necessary to designate a particular panel or panels to deal with doctors who had no settled address.
>
> If the Chairman of a regional panel was satisfied that a doctor should be invited to submit for examination, at least two members of the panel,

[1]See paragraphs 342–347.

including at least one psychiatrist, would be selected to examine the doctor. It should also be open to the doctor to nominate another psychiatrist, physician, neurologist, or any other doctor to examine and report on him. The information on which the panel Chairman had referred the doctor for examination would be made available to the examining doctors. The examining doctors should be asked to report only on the fitness of the doctor under review to engage in practice, either generally or on a limited basis, and the management of his case which they recommend. They would not be asked to make a recommendation whether the practitioner's registration should be suspended. The panel's recommendations as to management would be communicated to the Chairman of the panel and to the doctor, who would be asked to notify the Chairman whether he was prepared to accept the recommendations.

If the doctor accepted the recommendations of the panel and undertook treatment in accordance with them, his case need never be notified to the Council. Where however the doctor did not accept the recommendations, or if he refused to be examined, it would be open to the Chairman of the regional panel to notify the case to the Council; and a further procedure would need to be established to review the case centrally".

We appreciate the thinking behind these proposals. A system under which cases were considered initially at regional level would have many advantages. Local machinery would not be remote, it would be largely free from association with existing misconduct procedures, and—by spreading the load of cases—should resolve cases more quickly. It was suggested to us that NHS regions were sufficiently large to avoid local prejudice yet small enough to allow informal solution of problems. In short, what is being proposed is machinery designed to enable the sick doctor to be *persuaded* of what is best in the interest of the public, the profession, and himself. We were informed that the GMC, the British Medical Association, the defence societies, and many others all believed it to be necessary to establish local GMC machinery.

339. We are not convinced. We hold that local and informal machinery is required—but we cannot see that GMC local machinery would be better at the task of persuasion than other existing machinery, and in particular the NHS "three wise men" procedure and the procedure under paragraphs 40–42 of the terms of service for general practitioners.[1]

340. Were it just a question of whether GMC or NHS machinery was the more effective means of persuading sick doctors, we should not venture to set up our judgment in opposition to that so widely held within the profession. What persuades us to do so is our conviction of the necessity of a *supportive* approach to the problem of the sick doctor. By this we do not mean just kindness, tact, sympathy, and the other gentle virtues. We mean practical assistance—such as the re-arrangement of duties, the granting of sick leave, and help with remuneration and superannuation problems. GMC local committees could not provide this sort of support: for the foreseeable future it could come only from an employer and, in particular, the NHS. The great majority of cases of ill-health would occur within the NHS which already has its own

[1]This latter procedure involves the independent Local Medical Committees.

local health machinery, capable of offering practical assistance to the sick doctor. This machinery has deficiencies but those can—and we trust will—be corrected.

341. In our view, therefore, there would be no useful role for local GMC machinery. It could have no power of control over the sick doctor's right to practise nor could it provide any practical support or assistance. Accordingly we recommend that GMC machinery for dealing with the sick doctor should be exclusively central machinery—while resting firmly on the sub-structure of improved NHS machinery for dealing with sick doctors.

The Central machinery

(*a*) *The way cases would reach the Health Committee*

342. Cases where advice by other doctors or by employing authorities had failed should be notified to the GMC. (We see no practical difficulties in cases of doctors wholly in private practice being reported direct to the GMC following failure of colleagues' efforts.) The GMC would consider through its normal filtering machinery—that is the President and the Complaints Committee assisted as necessary by the investigating unit—what action was appropriate. Because it would not always be clear whether a case mainly concerned misconduct or health, this would have the practical advantage of allowing an informed decision to be taken on which response to a particular case was appropriate. Where cases were referred by the Complaints Committee to the Health Committee,[1] the matter ought, we recommend, to be handled initially by the latter body's Chairman. The purpose of this would be to allow a stage of "conciliation" within the GMC before a formal hearing. The normal procedure would, we recommend, be for the Chairman to invite the doctor to submit to medical examination by a specialist in the alleged disability. The examiner would be drawn from a panel of doctors appointed after consultation with professional organisations. The examining doctor would prepare a report containing his opinion on the extent of disability and his recommendations on what *medical* treatment was appropriate in the case. He would not express any view on whether formal control action should be taken by the GMC. Copies of the report would be sent to the doctor and to the Chairman. If the doctor accepted the findings of the medical examiner and gave a voluntary undertaking to seek treatment and to practise in accordance with any recommendations made by the Chairman, we believe the case need not be taken further unless it became clear subsequently that the doctor had broken his undertaking. Where the doctor did not accept the findings of the examination and the Chairman's recommendations, or where he refused to submit to examination, the Chairman would refer the matter to the full Committee.

(*b*) *The composition of the Health Committee*

343. We recommend that the Health Committee should consist of a Chairman and 10 other members of the GMC to include six members reaching the GMC by direct election, and four members reaching the GMC by the

[1]Because our proposals were much influenced by the GMC's suggested Mental Health Committee (although the remit of our Committee would also include physical illness) we do not intend to outline separately the GMC's proposals for central machinery.

nomination of an educational body. The quorum of the Health Committee, and the normal membership for dealing with cases should be the Chairman, or a deputy, and five of the committee chosen proportionally from its members. We make two comments on our proposal. First, we do not recommend a place on the panel for appointed lay members of the GMC. We found this a difficult decision to make. On the one hand, a lay member may be seen as a reassurance to the general public that their interests are being safeguarded. On the other hand, the Health Committee would in effect be making a clinical judgment on the fitness of a doctor appearing at a hearing. It must be doubtful whether a lay member would be able to do other than concur with the advice of his medical colleagues both on diagnosis and on appropriate control. On balance, we decided that it would be superfluous to provide for lay membership because we do not think that lay members would be able to make a real contribution to the Health Committee's work. Secondly, to ensure that cases are considered with the appropriate expertise, the Chairman should have power to co-opt expert advisers to assist the Committee in particular cases. The Chairman should also be able to call on the help of a legal assessor[1] if need be.

(*c*) *The procedure of the Health Committee*

344. While it would be generally administratively convenient for the Committee to hold meetings at regular intervals, it must also be possible to call additional meetings at short notice where the circumstances of a case suggested that delay might be dangerous. The Health Committee would consider the relevant evidence at a hearing held in private. The evidence would include the report of the medical examination and any medical evidence which the doctor wished to place before the Committee. If the doctor had refused to be examined by the GMC's nominee, the Committee would no doubt need to be particularly convinced of any medical evidence advanced on his behalf. Because of the seriousness of the matter, we believe that the rules of procedure to be adopted at the hearing would, like those of the Professional Conduct Committee, need to be laid down in subordinate legislation. These rules should be as simple as is consistent with a guarantee of uniformity and fairness and should be designed particularly to allow the doctor to put his side of the matter. The doctor would have the right to be present at the hearing and to be legally represented. We believe that it would be necessary for evidence to be given on oath and for the Committee to have the power to subpoena witnesses.

(*d*) *Courses of action*

345. At the end of the hearing we recommend that the Committee should be able to take one of the following courses of action in cases where unfitness had been established. It might first impose *conditional registration* to take effect for a fixed but renewable period. We envisage that this would be the most useful power available to the Committee as it would provide the GMC with flexible means to supervise a doctor's future action. Thus, the Health Committee might make continued registration conditional upon future attendance at a further hearing, regular treatment for the illness, or practice only under specified supervision or in particular areas of medicine. To assist periodic review of a case the Health Committee might call for regular reports

[1]See paragraph 302.

from the doctor's employer or, with the agreement of the doctor, his medical adviser.[1] We have said that the effectiveness of health controls on doctors unfit to practise because of ill-health would depend on the practical assistance that could be offered to assist restoration to good health. Under the present circumstances, the success of conditional registration would therefore depend on the co-operation of employing authorities with the GMC in the period of supervision. We do not envisage any major difficulty so far as the main employer of doctors, the NHS, is concerned in view of the Government's comment, "consideration should be given to providing a further new power to maintain a doctor on the register subject to conditions, such as the requirement to submit to medical treatment, or an understanding not to practise in a particular specialty". In amplification the Department of Health and Social Security said it would "be prepared to consider ways in which NHS authorities could be encouraged to collaborate in such arrangements—always provided the safety of patients was given the first consideration . . . in respect of doctors whose conduct had been found to be due to physical or mental ill-health". We welcome this.

346. Alternatively, the Committee might order a doctor's *suspension*. The Committee would order that the doctor's registration should cease to have effect for a period not exceeding 12 months, the suspension being subject to renewal. In extreme cases the Committee should have power to direct immediate suspension at the conclusion of the hearing. We recommend that suspension should be the most serious action that the Health Committee could take. For the Health Committee to say to a doctor, in effect, that he will never recover seems to us altogether too final in all but a minority of instances, and could well contribute to his complete breakdown, without hope of recovery. Even in the case of a long and often renewed suspension, the necessity for regular medical reports would certainly not put an undue burden upon the Committee, and it would be preferable to deal in this way with the few "irrecoverable" doctors rather than passing what would resemble a death sentence. It would, of course, be entirely open to the doctor concerned voluntarily to apply for erasure from the register should he decide to give up medical practice.

Appeal rights

347. While it is desirable that severe curtailment of a doctor's right of practice should be subject to review we recommend that the right of appeal should be limited to points of law; for example, where it was alleged that the Health Committee had failed to observe the correct procedures. We do not consider there could be an appeal on medical grounds as a decision of the Health Committee on the medical evidence before it would in effect be a matter of clinical judgment. No lay court would be able effectively to assess the merit of such a decision. We recommend that appeals against suspension or conditional registration should be to the same body that would hear appeals from the Professional Conduct Committee: that is, to the Judicial Committee of the Privy Council.

[1]The conditional registration proposed here is of course on the same footing as that proposed in paragraph 307.

Medical students

348. We deal here with the suggestion from the British Medical Association that there should be a formal assessment of mental and physical fitness for the medical student in order to "weed out" those students who, while possessing adequate academic ability, are otherwise unfit to practise medicine. It was suggested that a student should not be allowed to enter what is at present the pre-registration stage, thereby being barred from full registration, without a certificate of fitness to practise issued by the Dean of his medical school. We received later evidence to the effect that "this surreal proposal was 11 years ahead of its time" (the British Medical Association's suggestion was given to us in 1973). We do not accept the proposal, as we consider it wrong that any one person should have it in their power to prevent registration. The decision to withhold registration must be one for the regulating body and to ensure uniform criteria and maintain the regulating body's independence, that decision should not be prejudiced by an outside judgment. We recognise however that it can save a great deal of hardship if an obviously unsuitable medical student can be persuaded to seek a different career, preferably before he begins the clinical years. The problem will no doubt primarily affect students with a mental illness which is likely to prove irreversible, as those who have a physical disability will generally choose a field of practice where their disability will not be a disadvantage. We have no doubt that University staff should and indeed do see it as part of their responsibility to give appropriate advice to their students and that this is the most humane way of dissuading unsuitable students. We have also considered whether the new health controls we propose could be brought into play at the student stage. As the regulating body's controls must be related to registration it is difficult to see how its jurisdiction could be invoked before the student sought registration. The medical student must therefore receive treatment and advice primarily in the same way as any other member of the University. It would, however, be unnecessarily harsh for a doctor to be granted registration if his fitness to practise immediately thereafter is called into question. The student applying for registration thereby accepts the control of the registering body and this is the most appropriate time for control procedures to be initiated. Medical school authorities or others with knowledge of a potential doctor's disability might at this time inform the regulating body of their doubts and the health procedures could then be used to determine the candidate's fitness to practise. We hope that this would be a very rare occurrence and it would always be preferable if informal advice were accepted by the student. Our proposal is very much a back-up procedure and its chief effect may be to serve medical educators as a reminder of their responsibilities to their students and to the public and as a further argument when discussing with a student whether he should continue to aim at a medical career.

PART F: THE RESPECTIVE RESPONSIBILITIES OF THE NHS AND THE GMC IN RELATION TO FITNESS TO PRACTISE

349. The establishment of frontiers between the jurisdiction of the GMC and of the NHS in relation to fitness to practise raises a difficult question.

350. The NHS has powers, as will be clear from the description of them in Appendix D, to place very serious restrictions on the doctor's ability to practise. We have considered whether the NHS is so dominant as an employer that it ought to be restrained in its power to dispense with the services of doctors on grounds of their conduct or of their health. It should first be said that any sensible proposal for such a restraint would have to recognise the need for the NHS to have power to suspend a doctor while the GMC was looking at the question of his fitness to practise; and we believe therefore that argument of the necessity for urgent action is irrelevant in discussion of the case for retention of the present range of NHS controls. It can be argued that, because the NHS is not merely an employer of doctors but in a near monopoly position, the power of dismissal of the NHS should be subject to greater restrictions than exist in the normal employer/employee relationship. In this context we were struck by the Government's comment, "a direction by the NHS Tribunal that a doctor's name shall not be included on any [Family Practitioner Committee] list may be little less damaging to his livelihood in this country than a direction by the GMC Disciplinary Committee that his name shall be erased from the Register". For these reasons it can be credibly argued that any final decision on an individual doctor's fitness should be made by an outside body, the GMC, able to apply a uniform standard and free from the pressures which an employer might feel in the context of maintaining a service.

351. On the other hand, the arguments in favour of retention by the NHS of its present powers are as follows. First, as the main provider of medical services, the NHS has a large direct responsibility to the public and it would be unreasonable to expect the NHS to accept this responsibility in relation to doctors in whom it had no confidence. Secondly, the powers are clearly not used ruthlessly. The procedures described in Appendix D operate with the broad agreement of the profession who are in a position to scrutinize their administration especially since the procedures depend to a considerable extent on participation by members of the medical profession and others outside the NHS employing authorities. Thirdly, in practice it would be virtually impossible to define the limits of the respective jurisdictions. The NHS would have to retain the power to dismiss a doctor who failed to conform to his conditions of employment, but there would be circumstances where such a failure might raise the question of the doctor's general fitness to practise. For example, inability to work with colleagues might normally be considered to fall within the employing authority's remit, but in some circumstances such a failure might reflect on a doctor's general fitness. It might therefore lead to confusion if an attempt were made to define limits of responsibility.

352. In our judgment no absolutely clear division of responsibility between the NHS and the GMC in relation to fitness to practise can be made. So far as conduct is concerned, we recommend that a NHS authority should be able, as it is now, to dispense with the services of doctors on the grounds of their conduct subject to the qualification that a situation should be aimed at where the NHS restricted its control action to the maintenance of an efficient service and looked to the GMC for adjudication on professional matters of fitness to practise. What we have said about the passing of information from the NHS to the GMC

is also relevant here. So far as sick doctors are concerned we recommend that a general division of function between the NHS and the GMC ought to be developed under which the NHS would undertake the informal and directly supportive action to which we have referred, while the GMC dealt with the doctor who refused to co-operate or lacked insight into his condition so that compulsion became necessary.

PART G: CONCLUSIONS AND RECOMMENDATIONS

Our principal conclusions in Chapter 4

(22) Schemes of re-licensure could not supplant fitness to practise controls (paragraph 236).

(23) Effective control of doctors' fitness to practise depends primarily on the self respect of the medical profession (paragraphs 237–238).

(24) The position of persons reporting doctors to the GMC in relation to actions at law is noted (paragraph 261).

(25) The weight of evidence has shown broad acceptance of the existing GMC controls of professional conduct (paragraph 262).

(26) Supervision of doctors' professional conduct by the GMC must be firmly related to doctors' professional function; the GMC must be clear about its aims in supervising professional conduct and must communicate those aims effectively; and the GMC's procedure for considering individual cases of misconduct must be effective, sensitive and widely acceptable (paragraphs 270–285).

Our principal recommendations in Chapter 4

(37) The GMC should be able to take action in relation to the registration of a doctor whose condition or conduct requires it in the interest of the public (paragraph 232).

(38) The GMC should take fitness to practise action only over matters sufficiently serious to raise a question of a doctor's continued right to practise; and should where necessary carefully explain this limitation to persons complaining to them about doctors (paragraph 233).

(39) The GMC should be governed, in procedures in this field, by the wish to determine the fitness to practise of a doctor and not to punish him (paragraph 234).

(40) The institution of regular health tests for doctors with a view to securing more information about their fitness to practise is not desirable (paragraph 242).

(41) The imposition of statutory duties to report doctors' unfitness to practise is not desirable (paragraphs 243–247).

(42) There should be discussion between the GMC, the Health Departments, and representatives of the profession on the future provision of information from the NHS to the GMC (paragraphs 251–254).

(43) The GMC should be prepared to play an active role in obtaining information relevant to doctors' professional conduct, and should be provided with the means to mount its own investigations of doctors' conduct (paragraphs 255–259).

(44) The present practice of the GMC of allowing, very rarely, the maintenance of a complainant's anonymity should continue (paragraph 260).

(45) The medical legislation should continue to include a duty on the GMC to consider criminal convictions of doctors (paragraph 264).

(46) The test of professional conduct contained in the existing medical legislation should not be altered, and in particular a code of conduct is not recommended (paragraphs 266–267).

(47) The GMC should issue fuller guidance on the nature of professional misconduct (paragraph 268).

(48) The GMC ought not to commit itself to specific advice on what will constitute professional misconduct before the event (paragraph 269).

(49) The initial sifting of information coming to the GMC about doctors' professional conduct should be done by the President of the GMC who should not chair the committee hearing allegations of serious professional misconduct (paragraphs 287–289).

(50) A Complaints Committee should be established, the principal function of which would be to consider whether prima facie evidence that a doctor was not fit to practise had been assembled (paragraphs 290–292).

(51) The practice of the GMC in sending warning letters to doctors should be discontinued (paragraphs 294–295).

(52) The introduction of a "circumstantial letter", specifying what professional misconduct is alleged against a doctor, is not desirable; but greater openness in the GMC's procedure for acquainting doctors with the evidence in the GMC's possession is (paragraphs 296–298).

(53) A Professional Conduct Committee should be established, the function of which would be to consider doctors' criminal convictions and allegations against doctors of serious professional misconduct (paragraphs 299, 301 and 302).

(54) The introduction of a jury system for professional misconduct proceedings is not desirable (paragraph 300).

(55) The formal character of the proceedings of the GMC's Disciplinary Committee should be maintained in relation to the proceedings of the Professional Conduct Committee (paragraph 303).

(56) Decisions of the Professional Conduct Committee on individual cases should not require a two-thirds majority of the members of the Committee (paragraph 305).

(57) The range of sanctions to be used by the GMC against doctors who have been convicted of a criminal offence or found to have committed serious

professional misconduct should be enlarged in comparison with those at present available but should continue to be related solely to the doctor's right to practise (paragraphs 306 and 307).

(58) The GMC should have the power to order the immediate suspension of a doctor's right to practise in certain circumstances (paragraphs 292 and 308).

(59) The Professional Conduct Committee should not be required to accompany a decision in an individual case with a reasoned explanation of its judgment (paragraphs 309–311).

(60) There should be a right of appeal to the Judicial Committee of the Privy Council for a doctor against a decision of the Professional Conduct Committee affecting the terms on which he may practise (paragraphs 312–318).

(61) A right of appeal against GMC decisions on misconduct should not be conferred on complainants (paragraph 319).

(62) The existing arrangements governing restoration to the register subsequent to misconduct proceedings should continue in force with the changes necessary to take account of other alterations of practice (paragraph 320).

(63) The publicity given to misconduct proceedings should be controlled by legislation (paragraphs 321–327).

(64) The GMC should be empowered to control the right to practise of doctors whose mental or physical condition requires such control (paragraphs 328–336).

(65) The GMC should not establish local machinery to deal with doctors unfit to practise through illness; the local machinery needed for such doctors should be developed from existing NHS arrangements (paragraphs 337–341).

(66) A Health Committee should be established, the task of which would be to consider, under defined procedures, the registration of doctors unfit to practise through illness; in particular the Committee should have the power to suspend a doctor's registration or to impose conditional registration (paragraphs 342–346).

(67) A right of appeal, limited to points of law, to the Judicial Committee of the Privy Council, should be established against decisions of the Health Committee (paragraph 347).

(68) Medical students' entry upon what is at present the pre-registration year should not be made conditional upon a certificate of fitness to practise; but the formal health procedures might be used in the rare cases where registration is sought by a student about whose fitness to practise there is some doubt (paragraph 348).

(69) The NHS should retain its present power to dispense with the services of doctors, but should aim, firstly, to restrict its control of doctors' fitness to practise to matters pertaining to the maintenance of an efficient service, and, secondly, to provide support for the sick doctor (paragraphs 349–352).

CHAPTER 5: OTHER FUNCTIONS OF THE GMC

PART A: THE ESTABLISHMENT OF HIGH STANDARDS OF PROFESSIONAL CONDUCT

353. A general theme of our report has been the maintenance and often the *assertion* of high professional standards in the interests of the public. This part is concerned with one of the less large—but not less important—aspects of that assertion of standards. Here we deal with something for which the profession has a peculiar responsibility: the enormously increased power which science has put in the hands of doctors. The Government's evidence to us contained the following:

> "The doctor's increased resources of drugs and equipment enable him to intervene far more effectively than hitherto to alter the course of the patient's disease, to repair injuries and abnormalities, to transplant organs and so forth. Patients and the profession are alike conscious of the greatly increased power that science has placed in the hands of doctors".

There is no doubt of the truth of this; nor is there any doubt that the modern doctor is brought face to face with the widest human issues. Choosing which patient should receive the available transplant kidney is one example. Deciding the degree and direction of aggressive attitudes and conduct to be "therapeutically" fostered in a pathologically inhibited individual is another.

354. We asked the Government what were the sources of advice to the Secretary of State for Social Services on questions of medical ethics in clinical situations, and were told that "there is no one standing body or particular organisations to which the Secretary of State turns (or through which he channels requests) for advice on medical ethics in clinical (or indeed other) situations". The Government referred to advice published by the Medical Research Council and by the Royal College of Physicians and commented:

> "In recent months the Department has sought further advice from the Medical Research Council and Royal College of Physicians on a number of difficulties which have come to light in the application of the published guidelines to certain situations and on the composition and scope of ethical committees . . . Otherwise, the advice of various bodies set up by the Secretary of State in specialised areas often deals directly or indirectly with ethical questions. Clearly such bodies as the 'Advisory Committee on Renal Transplantation', the Committee on 'The Use of Foetuses and Foetal Material in Research' and the Committee whose report was entitled 'Advice from the Advisory Group on Transplantation Problems on the Question of Amending the Human Tissue Act 1961', cannot avoid entering into ethical matters".

At the clinical level, each NHS hospital is supposed to set up a committee to assist with ethical problems arising over research or treatment.

355. The British Medical Association told us of the machinery they have for providing ethical guidance. Defence societies have also considered ethical matters and there is the general guidance contained in the Hippocratic Oath and the World Medical Association 1948 Declaration of Geneva.

356. We do not believe that the present situation is satisfactory. In today's society the doctor is confronted by highly complex and technical problems that did not arise for his predecessors, and he accordingly needs a better channel of advice. We think this need can best be met by the GMC assuming an active rôle. We are far from believing that everyone else at present concerned with medical ethics should then shut up shop: indeed we believe it to be vital that discussion of the problems to which we have referred should take place as widely, as continuously, and under as many auspices, as possible. Nor are we so naive as to believe that the GMC could ever hope to dictate rules for doctors. What we believe the GMC can and should do is to be the centre of public debate, explaining—to the public as much as the profession—advising, and, if need be, warning.

357. The GMC indicated to us that it is initiating studies of the matter, and we received the following note on the subject:

"(*a*) The fact that certain types of professional misconduct had been described in the [advice the Council issues on professional misconduct] might have a limiting effect upon the readiness of members of the profession or of the public to bring to the notice of the Council other possible forms of misconduct which had not been so described.

(*b*) The [advice] deals only with modes of behaviour likely to be regarded as constituting serious professional misconduct. It gives no guidance either as to what might constitute high standards of professional conduct, or upon breaches of medical ethics so minor that they could not reasonably be regarded as amounting to serious professional misconduct.

(*c*) It could be argued that, in order fully to command the confidence of the profession, any central regulating body should, by its publicised activities, show that it is aware of new problems in the fields of professional conduct and that it is keeping in touch with the times . . .".

This statement seems to us, overall, to be rather too conscious of *mis*conduct as distinct from professional conduct in the light of new developments in medicine, but we welcome it as a further example of the GMC's willingness to review its activities in the course of our inquiry.

358. When any new medical legislation is drafted, we recommend that the GMC should be placed under a statutory duty to promote high standards of professional conduct so as to leave no doubt of its standing to act in this field.

PART B: PRETENDING TO BE A REGISTERED MEDICAL PRACTITIONER

Section 31 of the Medical Act 1956

359. Section 31 of the Medical Act 1956 is the provision directed against the person pretending to be registered so as to secure the benefits of registration in his approach to those he seeks to treat. It reads as follows:

"Any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary, shall be liable on summary conviction to a fine not exceeding five hundred pounds".

We understand that this provision and its predecessor has long been deemed unsatisfactory, primarily because of the inclusion of the word "wilfully". While it is easy to establish in any court that a person has falsely pretended to be a registered medical practitioner, or has falsely used a description commonly understood by the public to indicate a medically qualified practitioner, it is very difficult to establish that he has done so deliberately, that is, wilfully. We understand that this is why judges have drawn attention to the unsatisfactory state of this corner of the law since 1896.

What should the law be concerned with?

360. It is plain that there must be effective means of deterring false claims to medical qualifications; otherwise the public can easily be misled into seeking treatment from the unqualified. The existing legislation, if the word "wilfully" were deleted, would probably serve this purpose well enough, although it is possible that more flexible means of listing titles and qualifications should be adopted. But, whatever the means, we recommend that an effective offence be made of falsely claiming a medical title or qualification.

361. What is much more difficult is whether the legislation should be recast to restrict further the provision of medical treatment by anyone other than a registered medical practitioner. Section 34(1) of the Dentists' Act states that "a person who is not a registered dentist or a registered medical practitioner shall not practice or hold himself out, whether directly or by implication, as practising or as being prepared to practise dentistry". It is evidently fairly easy to identify what constitutes dentistry since it affects only a small area of the body and a particular range of treatment. There can be no question, in our view, of making medical treatment the preserve of registered medical practitioners in the way dentistry is the preserve of dentists and doctors: any attempt to do so could not avoid the absurdity of making it an offence for a relative or friend to advise a whisky toddy for a cold.

362. What we do recommend is a redesign of the legislation so that any person who is not a registered medical practitioner, and who offers medical treatment to the public, shall be obliged at the time of doing so to make clear that he is not registered. We do not think any difficulty need arise in legislating to refer to "medical treatment", because we believe the courts could determine whether "medical treatment" was offered or received on the facts of the case. What is difficult about the approach we suggest is the position of nurses, pharmacists, physiotherapists, psychologists and others offering forms of medical treatment. We believe that the solution to this difficulty is to exempt any properly attested members of such professions from the obligation we recommend be imposed.

The need for the change we recommend

363. Particularly since the establishment of a free NHS, anyone who is treated by an unregistered practitioner—a quack—is more likely to have sought him out than to have been deceived. Much quackery undoubtedly rests on the gullibility of the public—and one may have varying sympathy with such gullibility. What does seem to us to be particularly objectionable is the quackery that preys on fear or anxiety. Evidence we received showed that, at least in relation to the relief of mental states, such quackery is still with us. It is this factor which has weighed with us in recommending the strengthening of the existing provision.

The initiation of prosecutions

364. In the past, prosecutions under section 31 have generally been initiated by one of the medical defence societies. In the course of our work the defence society in question indicated that it no longer intended to bring such prosecutions. The British Medical Association expressed concern to us on learning of this. We believe that any person or body has a right—and sometimes a duty—to initiate action against unregistered practitioners. We see no reason why the British Medical Association or other associations of doctors should not mount prosecutions on information coming to them. We believe that the GMC, from its concern with the professional position of doctors, has a duty in this field. Accordingly we expect that the GMC might also mount prosecutions of persons pretending to be registered practitioners. On the other hand we think that it would be over-egging the pudding to place the GMC under a statutory duty to pursue unregistered practitioners.

PART C: THE MECHANICS OF REGISTRATION

365. We are concerned here with the actual *compilation* of the register.[1] A range of legislation depends on there being an exact means of verifying who is a doctor—or rather "registered medical practitioner". This list of practitioners must therefore be kept with very great care.

Who should keep the register ?

366. We think it possible that the compilation of the register could be undertaken by a body other than the one taking the important policy decisions about the conditions of entry to and exit from the register. Some small advantages, for example, being able to keep track of doctors with alcohol or similar problems, might be lost; but they are not very significant. On the other hand, we can think of no good reason why the task of compilation should be carried out separately; and it might be found that to do so was a little more costly and caused a little more confusion. Accordingly we recommend that the responsibility for maintaining the register should continue to rest with the GMC.

[1]To be exact, 'the Medical Register' is the annually printed publication and 'the register of medical practitioners' is an ongoing list. (See sections 1 and 9 of the Medical Act 1969.) The GMC publishes three-part fortnightly supplements so that the list is kept up to date. We refer to 'register' throughout this part so that, as the context requires it, the reference is either to the printed publication or the ongoing list.

The scope for rationalisation of lists of doctors

367. We received the following evidence from the British Medical Association:

> "It is the present rather parochial situation that a number of medical organisations each endeavours to keep an up-to-date list of some or all members of the medical profession for its own purposes—to name but some, the General Medical Council, the British Medical Association, the Department of Health and Social Security, the Medical Women's Federation, the Royal Society of Medicine, and the three Defence Organisations. In recent years, the BMA took the initiative in exploratory discussions on the possibility of establishing a central and 'neutral' joint mailing list which would contain basic essential information—name, address, sex and professional category—and which could be contained in a computer file accessible to each of the participating organisations. In addition, each organisation would be free to record additional material which would be accessible to that organisation alone. The BMA is advised that this would be a relatively simple exercise for a computer agency to carry out and that the maintenance of strict confidentiality is perfectly feasible. Further study of this proposal is recommended.
>
> "If some form of central computer file were set up, it would be legitimate for each of the participating organisations to contribute financially, in proportion to the benefits received. Whether or not future records are maintained in this form, the Government derives benefit from the publication of the Register, both in relation to the operation of the National Health Service, and in its rôle as protector of the public, since it is in the public interest that "persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners".

(We believe this evidence to have been prompted at least partly by a misunderstanding, which we deal with later,[1] about the cost of registration.) We received the following evidence from the Government:

> "The Health Departments consider that it will continue to be essential in the future, as in the past, for the names of doctors regarded as fit to practise to be readily available. The Department have noted that the BMA have drawn attention to what they describe as criticisms of the working of certain registration procedures under the present arrangements, and that there would appear to be scope for increased administrative efficiency. The BMA have also held exploratory discussions on the possibility of combining the operation of the register with other operations involving the listing of doctors and information about them. The Health Departments have not been able to assess the practicability of these suggestions but would agree that they should continue to be explored. Detailed study, including costings, would no doubt have to await decisions on the registration functions of the central regulating body'.

The GMC has told us that it is sceptical of the case for joint computer records: its argument being that it is one thing to set up a joint system when each of the partners has never before used computers, another altogether to do so when one at least of the partners has already a computerised system in operation.

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[1]In paragraph 425.

368. For our part we recommend that a dialogue be opened on these matters. We are unable to comment on the merits of any particular position: to do so would have required feasibility studies which we have not had the time or the resources to mount, even had we considered it appropriate for us to do so. It may be that proposals which seem superficially attractive would break down under such scrutiny: nevertheless it is sensible to keep office procedures under review. We are satisfied from the evidence we have received that our appointment has encouraged a willingness to look at these matters.

A more helpful register?

369. The primary purpose of the register, as a compilation of names, is, as we have said, that it provides an exact legal list of practitioners. If specialist registration on the lines we recommend is introduced, the register will be much more informative because it will show each doctor's specialty. Evidence we received from the Medical Practitioners' Union has prompted us to consider whether the helpfulness of the register could be improved in other ways. The Union pointed out that doctors over the age of 65 were not identified, and that a study they had made of the first four letters of the register suggested that it contained at least 80 doctors over the age of 85. The representatives of the Union argued that the register was only of value if it listed only persons fully capable of medical practice.

370. We do not think that it would be desirable to try to re-organise the register—for example, into geographical areas or by providing geographical indexing—so that it could be used as a *primary* means of choosing a doctor. We do think it possible to make the register more useful and informative and we recommend that the GMC should mount a careful study of the possibilities. The core of the suggestion made by the Medical Practitioners' Union—that the register should list separately those doctors who have retired from active practice —seems to us a prime candidate for inclusion in such a study. So too is the use of the power to register qualification: the question of whether the present range of additional qualification registered by the GMC is too restricted.

A practice certificate

371. We recommend that the GMC mount a study of the desirability of an annually issued practice certificate on the lines of that required of solicitors. The chief point of such a scheme would lie in requiring doctors to make a declaration of their continued fitness to practise. A further, and not insignificant, advantage of a practice certificate would be that it would largely eliminate the complaint with which we deal in the next section.

Doctors' registered addresses

372. If there is one thing more than another which has caused *individual* doctors to write to us it is over registered addresses. Doctors whose names have been erased from the register, either for not paying their annual retention fee or under the provision designed to ensure that registration entries are up to date, have complained bitterly to us that the GMC should have realised that their registered addresses were ineffective and communicated with them at other addresses. Such doctors have been particularly enraged because the letter

which informs them that they have been struck off the register is the first letter which the GMC finds possible to send to an effective address[1]. We think it right to quote extensively the GMC's evidence to us on this matter:

> "Since 1858 the Medical Acts have provided that the Register shall include, in relation to each doctor entered therein, his name, address and registered qualifications. The Medical Acts do not define the kind of address which should be entered in the Register in respect of each doctor. In particular the doctor is not required to give as his registered address the address from which he practises. A doctor's registered address may be of use to those who consult the Medical Register first in identifying a particular doctor (which frequently cannot be done from his name and qualifications alone) and secondly in establishing communication with him. The address is used by the Council for both these purposes. The address is therefore important to the doctor as being the address at which communications from the Council will be sent to him. The doctor's registered address is the address furnished for registration by the doctor and in connection with various matters [fees, correspondence on register entries, Council elections, disciplinary letters] the Registrar is required to write to the doctor at his registered address. These provisions afford a safeguard for the doctor, by preventing the Registrar from an arbitrary selection of an address, but the safeguard is effective only if the doctor maintains an effective registered address.
>
> "The question of addresses has always given rise to difficulty since with the passage of time the address notified by the doctor on first registration is likely to become obsolete. Nowadays, and for many years past, every doctor on first registration has been reminded in at least three separate documents issued to him by the Council of the need to inform the Council of changes of address so that the doctor's registered address will at all times afford a reliable channel of communication with him.
>
> "The Council would however be reluctant to undertake any general or continuing obligation to communciate with . . . doctors at addresses other than their registered address. The Council has taken the view that the responsibility must continue to rest upon the individual doctor to ensure that his registered address remains effective, and that communications to him from the Council should be sent to that address. The Fees Regulations are based upon this assumption. To proceed on any other basis would involve incurring, in favour of a minority who neglect to maintain effective registered addresses, additional expense which would fall on the whole profession. It might also lead more doctors to feel that they need not remember to notify changes of address to the Council, with the result that the proportion of ineffective addresses in the Register increased".

The argument about the unfairness to scrupulous doctors of having to meet the cost of administrative procedures to cope with careless ones is obviously cogent. In general we feel bound to accept it. On the other hand, erasure from the register means that the doctor is no longer entitled to practise in this country, so that, for example, the NHS is compelled to dispense with his

[1]This may be because a medical school or employing authority, upon noticing that the doctor has been struck off, writes to the GMC.

services, unless and until he is restored to the register. Notwithstanding the force of the GMC argument to which we have alluded, we therefore recommend that the GMC should be rather more flexible than it has been in the past over checking possible alternative addresses. In this connexion, we welcome the GMC's action, reported in its Annual Report from 1973, of sending additional letters to doctors whose addresses in the 'Medical Directory' were different from their registered addresses.

373. Indeed, our view of the problems that have arisen over registered addresses is that they are an example of the GMC's failure to communicate adequately with the members of the medical profession. The GMC points out that it tells doctors about the importance of the registered address when they first register, but we doubt whether that approach is the right one. We urge the GMC to seek publicity, either paying for it or by other means, through the medical press in order to explain such matters. We also think, as a detail of improved communication, that the GMC would be very well advised, where a doctor's effective address is discovered after his erasure, and the GMC writes to tell him of his erasure, to explain to the doctor how his address has since come to notice.

374. Taking this line of thought further, we recommend that the GMC mount a study of the possibility of introducing a common date for payment of the annual retention fee. The principal advantage of a common date would be the opportunity it would afford to fix in doctors' minds that there was a time of year at which to ensure their registered address was correct and pay their annual retention fee.

The registration function and legislation

375. The keeping of the register is regulated primarily by Sections 1–9 of the Medical Act 1969, and by various regulations made under that Act with the approval of the Privy Council. We are extremely sceptical of the need for all this legislation. We recommend that the need for it be reviewed as part of the preparation of the Medical Bill which will be needed if our report is implemented. More specifically we suggest examination of the following possibilities. First that the principal legislation relating to registration might extend no further than imposing a duty on the GMC—or, as at present, the Registrar—to maintain a register. Secondly, that in any event the principal legislation should not contain anything that can reasonably be put in subordinate legislation. Thirdly that what is in subordinate legislation be reviewed very carefully to see whether it would be appropriate to include it in rules internal to the GMC.

PART D: OUR PRINCIPAL RECOMMENDATIONS IN CHAPTER 5

(70) The GMC should be statutorily charged with the duty of promoting high standards of professional conduct (paragraphs 353–358).

(71) The provision making an offence of pretending to be a registered medical practitioner should be amended to make it wider ranging and more effective, and responsibility for initiating prosecutions under the provision should be widely accepted by bodies within the medical profession (paragraphs 359–364).

(72) The GMC should continue to maintain the medical register (paragraph 366).

(73) The GMC should enter into discussions with the Department of Health and Social Security and British Medical Association about the possibility of rationalisation of the keeping of various lists of doctors (paragraphs 367–368).

(74) The GMC should mount a study of the scope for making the medical register more informative and useful (paragraphs 369–370).

(75) The GMC should mount a study of the desirability of annually issued practice certificates (paragraph 371).

(76) The GMC should adopt a rather more flexible attitude over doctors' addresses (paragraphs 372–374).

(77) The legislation governing the keeping of the medical register should be thoroughly reviewed with a view to simplifying it greatly (paragraph 375).

CHAPTER 6: THE REGULATING BODY

PART A: GENERAL PRINCIPLES

376. This chapter is concerned with the machinery needed to maintain and assert the standards of the medical profession. We started work on it only after our chapters on functions were well advanced, and it has largely grown out of those earlier chapters. For example, we have proposed a very substantial increase in the GMC's responsibility for medical education, and this reinforces the need for the active participation in the GMC of those responsible for medical education. Similarly, the greater scope and effectiveness of the fitness to practise controls we recommend would not, we believe, be acceptable in the hands of a GMC as at present constituted.

Basic principles of composition

(*a*) *An independent GMC*

377. We do not believe we need to labour much the case for an independent GMC. One of the constant themes of our proposals on functions—particularly of those relating to admission to the medical register—has been the need for an assertion of the maintenance of standards unhindered by an immediate concern with the constraints imposed by resource of other limitations. We are sure that it would not add to the confidence of either the public or the profession to see medical standards in the charge of a body closely subordinate to the NHS or the Government. We therefore recommend an independent GMC.

(*b*) *A professional GMC*

378. We have remarked that the regulation of the medical profession may be regarded as reflecting a mutually advantageous contract between the public and the profession, and looked at from this point of view one could as well argue that the performance of the contract should be enforced by a regulating body of laymen as of doctors. It is the case that the medical profession has been regulated by a predominantly professional body for well over a century, and evidently a lay regulating body would labour under a substantial disadvantage. It is the essence of a professional skill that it deals with matters unfamiliar to the layman, and it follows that only those in the profession are in a position to judge many of the matters of standards of professional competence and conduct which will be involved.

379. We are in no doubt that the community will indeed be best served by a professional regulating body. At so many points, as we have remarked, it is on the self-respect of the medical profession that the public must rely for high standards of medicine. That is the essential argument for a predominantly professional regulating body and why we recommend a predominantly professional GMC. The ultimate safeguard of the public interest is in the power of Parliament. The new GMC will be established by Parliament through legislation, and Parliament will be able to intervene if the contract to which we have referred is not operating in the general public interest.

(*c*) *The nature of professional involvement*

380. We recommend a predominantly professional GMC and we believe that the GMC must—as at present—be representative of all parts of the profession, and in particular of those primarily concerned with medical education and those primarily concerned with direct patient care.

381. The regulation of medical education—arguably the GMC's most important task—requires the close co-operation of the principal educational bodies and it is clear that they must send members to the GMC. Such members will bring an expert knowledge of education to the deliberations of the GMC without which it is unlikely to command the respect and support of the educators. Furthermore the educational mechanism is much more likely to work if GMC aims are disseminated not only by paper and talk but in the minds of those who have taken part in the formative discussions. These members must be able to speak authoritatively for the educational bodies involved, so that prime responsibility for the method of their nomination must rest with the nominating bodies.

382. It is also essential that those doctors primarily concerned with the direct care of patients must be most strongly represented. All aspects of regulation, including the regulation of medical education, require their contribution; but their role will naturally be especially important in relation to the control of fitness to practise, since it is they who will have experience of ordinary practise. The most convenient way of choosing such members is undoubtedly through election by an electorate of registered medical practitioners. A system of election, whatever its faults may be in terms of domination by party, does mean that the electors have only themselves to blame for their representatives—and indeed their representatives' actions.

(*d*) *Lay involvement in the GMC*

383. We consider it important that some laymen should participate in the work of the GMC. We do not think this participation need be large because the presence of even a few laymen will change the perspective of proceedings, for example by preventing discussions taking place which reflect solely the common background which medical graduates will have. Lay members of the GMC may be expected, also, to focus attention on matters likely to worry ordinary members of the public. We wish to make it clear that in referring to lay members in the rest of this chapter we simply mean people other than doctors—in other words nurses or members of other professions, including those supplementary to medicine, would be included. We refer to the means of selecting these members in more detail later[1]; we believe they should be nominated by the Privy Council.

(*e*) *The balance of the new GMC*

384. We are quite sure that were the balance of the new GMC ever to become important in the sense of elected or other members making a side against the rest then the GMC would no longer be able effectively to regulate the profession

[1]In paragraph 403.

in the interest of the public. The balance of elected, nominated and lay members is nonetheless a significant matter, and we have paid careful attention to it in our consideration of each part of the regulating structure. A general theme of our proposals is the need to give elected members a dominant position in the new GMC.

Basic principles of structure

(*a*) *The possibility of dividing the regulating body into two*

385. We should like to dispose of one solution for the structure of the regulating body which is occasionally canvassed. This is that two bodies might be set up, one dealing with education and the other with all other regulatory matters. Such an approach, it is suggested, might ease the problem of securing a balance between educational interests and the interests of the members of the profession generally. We reject such a solution on two main grounds. We believe the various functions of the regulating body, namely, education, registration, and control of fitness to practise, are intimately linked. The aim of regulation is to maintain a list of qualified practitioners and we believe it would cause inconvenience to set up two separate bodies. In any case we suspect that the argument that the balance between educational and other interests could be made more easy is illusory: we do not think that the powers we propose that the GMC should have in relation to education would be acceptable to the general membership of the profession without their having an important say in the use of those powers.

(*b*) *The size of the regulating body*

386. We have had two wholly opposing views put to us about the size of the regulating body. It is suggested that it should be small essentially because then it will be cheaper and more efficient. The opposing view is that it should be large essentially because it will be more representative. In our judgment these views are not so contrasted as one might suppose, since we have come firmly to the conclusion that, however, one arranges the work of the GMC, both a large component and small components will be required. If one is to encompass and represent properly all those having a legitimate interest in the standards of the profession, both inside and outside, then it is clear the GMC must be large. It is just as clear that to give the work of the GMC coherence and direction it will have to have small executive elements to direct its day to day affairs. In short, the regulating structure must achieve a balance between active involvement of the many and efficient action by smaller groups.

387. We consider it to be important that the GMC should be constructed so as to ensure that its considerable powers and duties do not pass to a very few members, still less to officials. The GMC we are postulating will have very wide-reaching powers over the profession; the structure must be such that it is positive and effective in itself, control must be firm, clear and wielded by the members. It must above all be responsive to the needs and wishes of the public and of the profession.

Our proposals

388. To set up the new GMC, legislation will be required. We have no doubt that before bringing forward such legislation the responsible Ministers will consult widely. Neither are we in any doubt that the task of drafting instructions for Parliamentary Counsel for a Bill to set up the new GMC is a matter for the responsible Ministers and not for us. Both these consideraions lead us firmly to conclude that our task must be to set out argued views which the Government and other interested parties can consider, and not to try to settle every matter of detail. We have already set out our views on the broad principles of the composition and structure of the regulating body; we now put forward our suggestions on how these should be put into operation.

PART B: OUR DETAILED STRUCTURAL PROPOSALS

General summary

389. A diagram on the next page outlines our ideas for the structure of the new GMC. We recommend that the whole organisation should continue to be called the "General Medical Council". Within that there should be a General Council consisting of members directly elected by registered medical practitioners, members appointed by certain bodies involved in medical education and lay members appointed by the Privy Council. The General Council should elect, in some cases collectively, in others through its constituent groups, a structure of committees. The general Council should elect a Chairman who, apart from chairing General Council meetings, should be concerned with seeing that the views of the General Council are most fully taken into account by the executive structure. We recommend that the General Council should elect a President to head the executive and be responsible for answering to the General Council for the work of the executive.

The composition of the General Council

(*a*) *Balance*

390. We have explained why we believe that directly elected members should have a dominant position on the GMC. We recommend that the directly elected members should exceed all other members by 10. Subject to uncertainty about the number of members nominated by educational institutions we recommend that the General Council should comprise 54 directly elected members, 34 members nominated by educational institutions, and 10 lay members appointed by the Crown—total 98 members. We are much concerned with *all* aspects of the balance of the GMC and we stress here that our proposals are the outcome of careful consideration of the balance between the countries of the United Kingdom and the balance also between male and female, young and old, and general practitioner, hospital doctor and academic doctor.

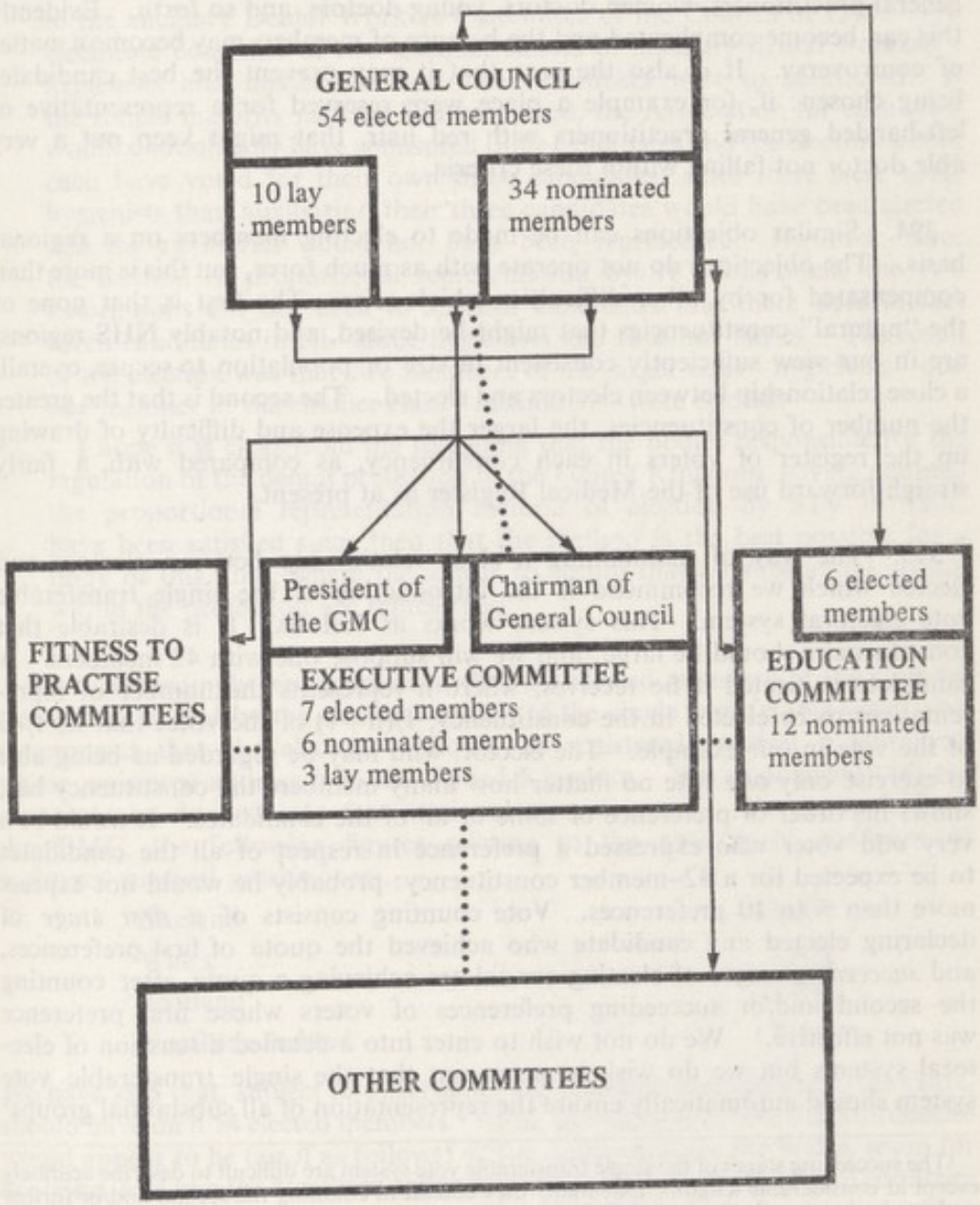
(*b*) *General conditions of tenure*

391. We recommend that the term of office of all members—elected, nominated, or lay—should be four years with no restriction on re-appointment or re-election save an age restriction. We recommend that nobody should be eligible for appointment or election after his sixty-sixth birthday—thus ensuring that no member of the General Council will be over 70.

A SUGGESTED STRUCTURE FOR THE GENERAL MEDICAL COUNCIL

A line with arrows in it represents an elective process.

A dotted line represents a co-ordinating function.



(c) *Elected members*

392. We have said that we regard it as essential that the GMC should be as widely representative of the profession as possible: which is to say that every member of the profession should feel that there is someone whom he can regard as fully aware of his point of view, and with whom he feels he can communicate without difficulty. Accordingly we examined various ways in which such a close relationship between the elected membership of the GMC and the electorate might be achieved.

393. One way would be to reserve special places for hospital doctors, general practitioners, women doctors, young doctors, and so forth. Evidently this can become complicated and the balance of members may become a matter of controversy. It is also the case that it may prevent the best candidates being chosen: if, for example a place were reserved for a representative of left-handed general practitioners with red hair, that might keep out a very able doctor not falling within these criteria.

394. Similar objections can be made to electing members on a regional basis. The objections do not operate with as much force, but this is more than compensated for by other difficulties which arise. The first is that none of the "natural" constituencies that might be devised, and notably NHS regions, are in our view sufficiently consistent in size or population to secure, overall, a close relationship between electors and elected. The second is that the greater the number of constituencies, the larger the expense and difficulty of drawing up the register of voters in each constituency, as compared with a fairly straightforward use of the Medical Register as at present.

395. The way of maintaining a close relationship between electors and elected which we recommend is the introduction of the single transferable vote electoral system. This system works as follows. It is desirable that constituencies should be large; and we will suppose one with 42 members. A candidate is elected if he receives, where n represents the number of representatives to be elected in the constituency, $1/(n+1)$ of the vote: that is, 1/43 of the vote in our example. The elector, who may be regarded as being able to exercise only *one* vote no matter how many members the constituency has, shows his order of preference of some or all of the candidates. It would be a very odd voter who expressed a preference in respect of all the candidates to be expected for a 42–member constituency: probably he would not express more than 5 to 10 preferences. Vote counting consists of a *first stage* of declaring elected any candidate who achieved the quota of first preferences, and *succeeding stages* of electing candidates achieving a quota after counting the second and/or succeeding preferences of voters whose first preference was not effective.[1] We do not wish to enter into a detailed discussion of electoral systems but we do wish to point out that the single transferable vote system should automatically ensure the representation of all substantial groups[2]

[1]The succeeding stages of the single transferable vote system are difficult to describe acurately except at considerable length. Essentially they consist in counting the second and/or further preferences expressed where a candidate has a surplus over that required for election, or is at the bottom of the poll.

[2]On the basis of 54 elected members for an electorate of 79,000, 1,500 determined electors could rely on sending their own man forward.

since it allows every voter to indicate his personal preference with the maximum clarity. Since this is so, it is not necessary to adopt devices such as regular elections of a proportion of the members to keep in touch with changes in electoral opinion.

396. The single transferable vote is used by several professional bodies and notably the General Dental Council. We received the following evidence from the Council on the effectiveness of the system:

> "The fact that proportional representation by STV works as intended was demonstrated very simply and clearly by the election of ancillaries to the ancillary Dental Workers Committee of the Council in 1970. The electorate consisted of two unequal classes of ancillary dental workers—hygienists and auxiliaries—and three members were to be elected. If the simple majority method had been used, the Association for each class would undoubtedly have sponsored three candidates and the electors would each have voted for their own three candidates; since there were more hygienists than auxiliaries, their three candidates would have been elected and the auxiliaries would not have been represented. However, since the method of proportional representation by STV was used, the two associations did not need to sponsor candidates and there were in fact seven candidates in all—three hygienists and four auxiliaries. The result of the election was that two members of the larger class—hygienists—and one member of the smaller class—auxiliaries—were elected.
>
> I hope it is clear from the foregoing that the bodies responsible for the regulation of the dental profession in the United Kingdom, having adopted the proportional representation method of election by STV in 1921, have been satisfied since then that the method is the best possible for a body of this kind, where the aim is to secure that all substantial groups within the profession are represented".

397. Accordingly we recommend that the elected members of the General Council be elected by the electoral system of the single transferable vote. We recommend that the electorate should be registered medical practitioners whose registered address is in the United Kingdom. We recommend that the electorate be divided into four national constituencies. We received, from the GMC, the following figures relating to the country of residence of registered medical practitioners.

England	63,000
Wales	4,000
Scotland	10,000
Northern Ireland	2,000

We have said that, subject to uncertainty about nominated members, the GMC should have on it 54 elected members. If so, the division between constituencies would appear to be fair if as follows: 42 for England, three for Wales, seven for Scotland, and two for Northern Ireland. This may not appear to give countries other than England as strong a representation as might be desired. In looking at this aspect it must not be forgotten that many of the university and college representatives would come from countries other than England, and so, as we

recommended later, would some of the lay members. Scotland, for example, would send at least 16 members to a 98 member GMC, if our recommendations were implemented.

398. We have mentioned our consideration of the possibility of places for special groups of doctors. For no group was our inclination to recommend a special place stronger than for young doctors. We believe that special provision for them is essential for two reasons. First, a major part of the GMC's work will be education and those who have recently undergone the process, or indeed are still involved in it, have a special contribution to make. Secondly, there is a particular difficulty in getting the young to come forward to be elected. Accordingly we believe it essential to make special arrangements to ensure that young doctors—whom we define, and recommend should be officially defined, as doctors within seven years (roughly equivalent to the length of postgraduate training) of initial registration—stand for election to the General Council. We hope that young doctors or organisations representative of them will always ensure that at least eight young doctors are always nominated in any election. In case this fails, we suggest that the Clerk of the Privy Council, after consulting organisations representative of young doctors, should be enabled to nominate sufficient young doctors to bring the number standing for election up to eight. The outcome of the election is of course a matter for all doctors, including the young ones.

399. More generally we believe that it should be made easy to nominate someone for the election. We believe also that the Registrar of the GMC should not only publish electoral arrangements in the medical press but also circularise all NHS authorities—as a convenient way of bringing the matter to doctors' attention—pointing out the possibility of nominating a candidate.

400. We have encountered a good deal of disquiet about the difficulty of learning about candidates under the present arrangements for election to the GMC. On this subject we were interested by a paragraph in the report of one of our predecessors, the Working Party on the composition of the General Medical Council which was set up by the GMC, the British Medical Association and the Royal Colleges under the chairmanship of Sir Brynmor Jones, and which reported in 1971:

> "39 The Working Party has also given consideration to the question of arrangements for giving information to the voters about the candidates in any election. The present electoral scheme, and its predecessor, provides that the voting papers shall state the names, registered addresses and registered qualifications of each duly nominated candidate in the constituency. The Registrar of the Council (who in practice organises the election and acts as Returning Officer) has no power to include with the voting papers any other information about the candidates, nor can he disseminate electoral addresses. Suggestions have been made from time to time that the Registrar should be empowered to circulate other information.
>
> This could either be of a factual biographical nature or could consist of addresses supplied by the candidates and not exceeding a specified length. While the Working Party appreciates the need of the electorate

for sufficient information about the candidates on which to cast their votes intelligently, there are considerable objections to such information being disseminated by the person responsible for the conduct of the election. It would in practice be difficult to distinguish between factual information (unless this were severely limited) and material which, though purporting to be biographical, was in fact calculated to promote the election of a candidate. The Registrar should not be called upon at short notice to distinguish between the two, nor should he be requested to disseminate literature provided by the candidates which could well contain critical and offensive remarks about the Council and its previous members".

It will be evident that our concern to ensure the representation of a wide variety of interests has led us to consider this most carefully. We believe first, that the point about the Registrar's dilemma does rule out the possibility of conferring on candidates an unrestricted privilege to have a policy manifesto included with voting papers. We believe, secondly, that each candidates Medical Register entry should be included. We suggest, thirdly, that each candidate should contribute, say, 50 words about himself. We do not believe that the difficulty for the Registrar referred to in the extract from the Brynmor Jones report need prove a bar to this suggestion. The point of allowing the candidate to write 50 words about himself would be to give factual details of his own career. If he chose to abuse this privilege by including material soliciting votes that would be his business. All electorates are more sophisticated than they are given credit for, and the medical electorate is not likely to be an exception to this rule.

401. For the filling of casual vacancies we recommend that, at any election, reserves be declared who can fill any vacancy arising during the period of office. Elections are expensive, and we do not think it would be justifiable to embark on the expense of one to fill casual vacancies. Furthermore the method we propose should always ensure that the representatives of countries other than England are maintained at full strength.

(*d*) *Nominated members*

402. Wide consultation will be necessary to arrive at the list to be included in legislation of educational bodies which should be empowered to nominate members of the General Council. We offer the following list as a *starting point* for that consultation:

The universities of Aberdeen, Belfast, Birmingham, Bristol, Cambridge, Dundee, Edinburgh, Glasgow, Leeds, Leicester, Liverpool, London, Manchester, Newcastle, Nottingham, Oxford, Sheffield, Southampton, and Wales.

The Apothecaries' Society of London, the Royal Colleges of Physicians of London, Surgeons of England, Obstetricians and Gynaecologists, Physicians of Edinburgh, Surgeons of Edinburgh, Physicians and Surgeons of Glasgow, General Practitioners, Pathologists, and Psychiatrists and the Faculties of Radiologists, Anaesthetists, and Community Medicine.

We believe that each of these 32 institutions should nominate one member save the University of London which should, we recommend, nominate three

members not only on account of the size, from 12 medical schools, of its undergraduate interests but also on account of its extensive postgraduate responsibilities. As to how the nominated representatives arrive in the General Council we have said that we believe this is essentially a matter for the nominating bodies to decide, since the justification for their being on the GMC is essentially the *functional* one. We hope, however, that universities and other institutions would not be wholly unsympathetic to the view that the members of such institutions should have some say in the process of nomination.

(*e*) *Appointed members*

403. We have explained[1] that we believe that there should be lay participation in the GMC. It appears clear to us that these members, who are in some sense the public's voice on the GMC, cannot be placed on the General Council through any electoral system, or their election or nomination left to the medical profession. We therefore recommend that the responsibility for nominating lay members of the GMC should rest with the Privy Council. We hope that the Council would make lay appointments only after wide consultation with Government Departments and with NHS authorities involved closely with the public. We believe that machinery for this function will need to be worked out: the most promising possibility in our view is that NHS authorities be asked to suggest names to the Privy Council. We hope that the lay representation on the body would provide the same spectrum of interest and age which we would hope to see among the medical members of the body. We do not believe that the difficulties of appointing members engaged in a wide variety of employment are insuperable. As to their number, we believe 10 to be appropriate. We believe that of the 10 members one each should be nominated for Northern Ireland and for Wales, two for Scotland and six for England.

404. We pause here to compare our proposals with the existing arrangements under which the Crown appoints members to the GMC. Some of the Crown appointed members are legislatively required to be doctors; we suggest 10 lay members. We are aware that it has become the custom for the Crown to appoint the Health Service Departments' Chief Medical Officers, or very immediate deputies, to the GMC. These doctors have brought to the GMC not only their intimate knowledge of the health service, but also their very particular professional capabilities, which have clearly been of great value. In considering this situation, we have had to resolve a conflict between the obvious necessity for the close involvement of the Chief Medical Officers and the general principle to which we are attached, which postulates an overriding need for the separation of the setting of standards from the provision of services. We regard the latter as sufficiently important to require that the participation of Departmental representatives should be on an assessor or observer basis.

(*f*) *Nominated members and the balance of the GMC*

405. From time to time the need will no doubt arise to alter the representation of educational bodies. We recommend that this should be capable of achievement much as at present, that is by means of subordinate legislation; and with corresponding power to maintain the appropriate balance of membership.

[1]In paragraph 383.

(*g*) *Ireland*

406. At present the GMC is constituted on a British Isles basis, with representation of the Irish Republic. We understand that there has always been fruitful co-operation between the GMC and the Medical Registration Council of the Irish Republic. We very much hope that this will continue, and that in particular reciprocal rights of practice will continue to exist between the two countries until European harmonisation makes them unnecessary. Nevertheless we regard it as no longer appropriate that the Irish Republic should send members to the GMC.

The task of the General Council

407. We wish to make three points about the task we see the General Council as fulfilling. Its first important power will be in relation to general policy. We conceive it as a forum for the discussion of and decisions on broad policy. A body of the size we propose would in ordinary circumstances be rather large for the effective discussion of policy. Two circumstances of the regulating body we propose would not, however, be ordinary. The first is that all members would be likely to be actively engaged in the work of regulation, because of the need to share the work of the three committees concerned with fitness to practise which we propose, and the work of regulating medical education. Secondly, the large general questions of regulation are not matters where policy changes from day to day. Indeed it would be intolerable if, for example, a medical student did not know, when he began it, how long his undergraduate course would last or the broad content of his instruction. Bearing in mind these two considerations we believe that the General Council we propose may be expected to make a firm and effective contribution to determining the general policy of regulating the medical profession. The second important power of the General Council will be to elect the members of the other parts of the structure we recommend and in particular the statutory committees. We wish to point out, thirdly that, any other part of the regulating structure, if appointed by the General Council, must needs retain its confidence. Although we do not conceive the institutionalisation of the General Council in a way which would make it ordinary for motions of no confidence to be put down on other parts of the regulating structure, if another part of the regulating structure lost the confidence of a majority of the General Council, the members of that other part could hardly do other than resign.

408. As a particular point we recommend that the General Council should meet at least twice a year.

The executive structure

409. We deal here with the parts of the executive structure which we believe should be recognised in legislation. The GMC will of course need other officers and committees but we believe that their establishment can be left to the GMC.

(*a*) *The President of the GMC*

410. We recommend that the General Council should elect a President of the GMC. He would be head of the executive structure, in particular chairing the

Executive Committee and, as we have mentioned in chapter 4, taking responsibility for the preliminary sifting of complaints against doctors. He should, we recommend, be elected by the single transferable vote electoral system by all members of the General Council voting together. He should be elected for a two year term but be eligible for re-election. He should not, we recommend, chair General Council meetings: he will be the better able to account to the General Council for his and the Executive Committee's stewardship if he is free of such responsibility.

(*b*) *The Chairman of the General Council*

411. We recommend that the General Council should elect a Chairman to chair meetings of the General Council. He would be responsible for ensuring that the policy of the General Council is observed by the executive structure of the GMC. He should, we recommend, be elected in the same manner and on the same conditions as the President and should be ex officio a member of the Executive Committee.

(*c*) *The Executive Committee*

412. It is clear that a General Council of the size we believe necessary is not capable of carrying day to day executive responsibility. To mention the most obvious difficulty, the practical awkwardness of convening the Council frequently enough would be very great. No institution of the power and standing of the body we propose could possibly proceed without a considerable devolution of both labour and executive responsibility. For this reason, therefore, we see the need for an executive committee. The major responsibility of this committee would be to see to the implementation of the policies decided on by the General Council. The committee would also be a source of new ideas and become the leader and guide of the General Council.

413. We recommend that the structure of the executive committee should be as follows. The Chairman should be the President of the GMC, whose appointment we have already discussed. The Chairman of the General Council should be a member of the executive committee ex officio. We recommend 16 other members with the following in common. They should all be members of the General Council. They should be elected, on the single transferable vote system, by all members of the General Council voting together. They should hold office for two years but be eligible for re-election. Of the 16, three should be members of the General Council nominated to that body by universities, three should be members of the General Council nominated to that body by educational bodies other than universities, seven should be members directly elected to the General Council, and three should be lay members of the General Council.

(*d*) *Eligibility for re-election*

414. We make one general observation here which stems from our recommendations that the President, Chairman, and Executive Committee should be eligible for re-election, so that, formerly, their term of office would be restricted only when they reached an age where one could no longer be a member of the General Council. We believe that the possibility of re-election should not be distorted to mean that re-election is a formality, and we should expect those who have been elected to be the prime guardians of the doctrine.

(e) *Fitness to practise committees*

415. We have dealt with the precise composition of the fitness to practise committees in chapter 4,[1] but there are some general points we wish to make here. It will have been noted that we recommend that directly elected members of the GMC should be in a majority on all three fitness to practise committees. Lay members, and members appointed by educational bodies will have a substantial contribution to make to fitness to practise proceedings. We believe, however, that controls of doctors' fitness to practise should be carried out primarily by those best in a position to understand the circumstances of everyday practice. Secondly, we recommend that no member of the GMC, including the President should sit on more than one fitness to practise committee. Thirdly, we have recommended that the members of the three committees should be drawn from panels twice the size of the committees needed for hearings. Such an arrangement has the practical advantage of spreading the burden of participation in fitness to practise proceedings. Finally, members of the panels should be elected, on the single transferable vote system, by all members of the General Council voting together. Panel members should, we recommend, hold office for two years and be eligible for re-election.

(f) *The Education Committee*

416. We recommend the establishment of an education committee. This committee would carry out the main work of regulating medical education. If our recommendations in relation to post-graduate education are carried out, it would have a particularly onerous task over the few years following its establishment. Just as we would not expect the executive committee to interfere in the ordinary work of the fitness to practise committees, so we would not expect the executive committee to interfere in the ordinary work of the education committee. Nevertheless the education committee would work under the general direction of the executive committee.

417. We recommend that the committee should consist of a chairman, chosen by the committee from among its number, and 18 other members. Of these 18 members, six would be members nominated to the General Council by the universities, six would be members nominated to the General Council by other educational bodies, and six would be directly elected members of the General Council. These 18 members should, we recommend, be elected to the committee by the single transferable vote system, the 12 educational members by an electorate composed of the nominated members of the General Council, and the six directly elected members by an electorate composed of the directly elected members of the General Council. We recommend that the committee should have the power to co-opt further members.

418. We have recommended in chapter 2 that medical education should be *organisationally* a continuum, and the nominated members of this committee will, of course, represent each of the phases of medical education. It seems to us particularly important that the elected members on the committee should include some young doctors, and we believe that the single transferable vote

[1]See paragraphs 293, 301–302.

electoral system will ensure that they do. In the event that they do not, we have no doubt that the committee would see the importance of using their powers of co-option to ensure that they heard the voices of those undergoing education.

Our structural proposals and legislation

419. The following suggestions on the legislative means by which our proposals might be implemented are made with a view to securing simplicity and a reasonable amount of flexibility. We suggest that the principal legislation need do little more than say that there shall be a GMC consisting of a General Council having on it elected, appointed, and lay members. The listing of bodies having a right to appoint members to, and the number of elected and lay members of, the General Council should, we suggest, be left to subordinate legislation. We believe that the Executive Committee, the Education Committee, the President of the GMC, and the Chairman of the General Council, should all be provided for in subordinate legislation. We believe that, as now, the election of members to the General Council should be controlled by an electoral scheme made by the GMC with the consent of the Privy Council after consulting organisations representative of doctors.

PART C: THE FINANCE OF THE GMC

The present position

420. By far the greater part of the GMC's income is at present derived from fees collected from the profession in the course of the maintenance of a register of qualified medical practitioners. For example, in 1973, registration fees, including the annual retention fee, provided £629,002 out of a total income of £662,579. The money is collected under various powers. So far as provisional and full registration are concerned, section 5 of the Medical Act 1969 empowers the GMC to "make regulations with respect to the charging of fees in connection with the making of entries in the register". These regulations must be approved by an order of the Privy Council before they take effect and they thereby become part of the law of the land. The current regulations are the General Medical Council (Registration (Fees) Regulations) Order of Council 1972. Since 1970, in addition to fees payable on registration there has been an annual retention fee, the present level being £5. Holders of temporary registration also pay a combination of initial registration fees and renewal fees.

Background to the present situation

(*a*) *The GMC's financial problems*

421. Originally the system for financing the GMC was very simple. The Medical Act 1858 empowered the GMC to charge a maximum fee of £5 for initial registration and this maximum remained unaltered until 1950. Since that time provisional registration has been introduced and the general level of registration fees has been increased periodically. Notwithstanding such increases the financial position of the GMC became increasingly precarious during the nineteen-sixties. The accounts for the years 1960–1969 showed a steadily rising total of expenditure from £55,509 to £219,596. We understand

that the reasons for this increase were as follows: the general effect of inflation, which caused increase in such things as staff salaries, rates, heating, lighting, printing and legal costs; the increased size of the register[1]; the increasing cost of the disciplinary rôle of the GMC; the computerisation of the register; the leasing of additional premises necessitated by the increase in work; the introduction of a superannuation scheme, and in latter years the payment of interest on the bank overdrafts to cover the deficit. By contrast, the income did not grow proportionally, increasing from £64,411 in 1960, when there was a surplus of £8,902, to £169,947 in 1969, when there was a deficit of £49,649. During these years it could be said that doctors from overseas were subsidising those educated in this country as a substantial percentage of the GMC's income came from this source. For example, in 1961 fees from overseas doctors amounted to nearly £31,000 out of a total income of £70,211. Not surprisingly, the GMC took the view that this was not a satisfactory situation.

(*b*) *The introduction of the annual retention fee*

422. As an alternative source of income, the GMC first proposed an annual retention fee in 1963. Enabling legislation was passed in 1969, and the GMC set about preparing new regulations incorporating an annual fee. Before deciding to press ahead with the fee, the GMC considered alternative methods of raising the money. It was estimated that, were the GMC to rely merely on increased initial registration fees, it would be necessary to increase such fees very substantially with the likelihood of a further large increase within a few years. Such an increase in initial fees was not considered acceptable by the GMC. The GMC also considered whether its expenditure could be financed by the institution of an annual retention fee payable only by doctors first registered *after* the introduction of such arrangements. We understand that this would have meant an annual retention fee of at least £20 and that even this would not have produced sufficient income in the early years of the scheme. The GMC took the view that it would be inequitable to place such a financial burden on young doctors at the outset of their careers. As a result an annual retention fee of £2 was introduced payable by all doctors other than those falling within certain categories[2], and those overseas doctors with temporary registration[3]. The annual fee was increased to £5 a year from May, 1972.

(*c*) *Opposition to the annual retention fee*

423. The introduction of the annual retention fee was resented by sections of the medical profession. There seem to us to have been two main facets to the opposition. First, the fee was opposed by many doctors who had paid their initial registration fee on the assumption that this was a lifetime payment and therefore considered that it was sharp practice of the GMC to ask for further money. As an example of the strong feeling aroused amongst individual practitioners, one doctor told us the following:

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[1]Though this of course also meant increased income from registration fees.

[2]For example, those over 65, those non-resident in the British Isles, those suffering from lasting physical incapacity, and those with provisional registration provided they proceeded to full registration within two years.

[3]Who were however required to pay renewal fees at a similar level.

"In 1970 came my disillusionment and my first professional contact for 33 years with the GMC. The enabling Act of 1969 had been slipped through without adequate preparation or prior consultation with the profession. By a legally correct but morally indefensible decision a 'retaining fee' of £2 pa. was imposed on all registered practitioners . . .".

Secondly, many doctors who accepted that the GMC needed additional income, nonetheless objected to paying for a body which was not considered to be representative of the profession. As a financial issue this became entwined with the campaign for a majority of the GMC's members to be elected directly by the profession. In a sense this aspect of the issue can perhaps be summed up by the parliamentary rallying cry of "no taxation without representation".

(*d*) *The GMC's financial problems not due to mismanagement*

424. Before considering the future finance of the GMC we wish to lay to rest the suggestion that the GMC's financial troubles were the result of its own mismanagement of its resources. We consider that this can best be done by reference to a report on the GMC's financial procedures by a firm of accountants, McLintock Mann and Whitney Murray, which was published in the British Medical Journal of 15th July 1972. The report was commissioned by the GMC in response to criticisms, and the firm which had not previously been retained by the GMC was selected in consultation with the British Medical Association. While containing a number of suggestions for improvements and modifications in procedure, the report made the general comment.

"We have found that during the last three years certain fundamental changes have been made to the financial and organisational procedures of the Council. We are of the opinion that these changes have been generally effective, and that the administrative staff is in no way indifferent to the ordinary considerations of prudence and economy. We have found no evidence of any waste or misuse of funds".

(*e*) *A misunderstanding about the cost of the register*

425. We refer here to a particular misunderstanding that arose in the evidence about the work of the GMC: that is, the expense involved in producing the register. In evidence to us, the British Medical Association suggested that the cost of "producing and publishing the Register (£131,000 in 1972 out of £376,000) forms a considerable part of the total expenditure of the General Medical Council". We think it right to point out that the figure of £131,000 is misleading. It includes the cost of *all* registration work of which £43,000 was attributable to registration itself rather than the production of the register. While it might be arguable that the £43,000 was part of the cost of the register in a general sense, it is certainly not correct to include another £70,000 incurred in collecting the annual retention fee. For 1972 the printing and associated staff costs of the register were £27,535. Against that can be offset sales figures of £20,641. On that basis the true cost of "producing and publishing" the register was £6,074.

How the GMC should be financed in future

(*a*) *The evidence*

426. Three options were put to us in evidence as means of financing the future GMC: funding exclusively by the profession, funding exclusively by the Government, and a mixture of the two methods. In support of the first possibility it was argued that, if the profession wished to be regulated by an independent body, then the profession must pay; it being suggested that Government funding would carry the risk of impairment of independence. On the other hand, we were also told that, if the purpose of the GMC was to protect the public, then the public should pay. Thus the Medical Practitioners Union commented as follows:

> "The object of regulating the medical profession is to co-ordinate its activities so that it can best serve the people . . . the service involved in the control of the medical profession should be a service to the community as a whole not to the medical profession as such. On grounds of principle, therefore, MPU are against any such charge."

In addition, from the point of view of a lay organisation MIND (National Association for Mental Health) commented that the "financing of the regulating body should not depend on members' contributions, or it becomes impossible to avoid the suspicion of the body's being concerned with professional rather than public interest". The most common view was that there should be some form of dual funding, the most favoured area of subsidy being the keeping of the Register. The Royal College of Physicians commented as follows:

> "If (and this is believed to be the case) it is the wish of the medical profession for their affairs to be regulated by an independent body then it would seem not unreasonable for those on the register to pay a retention fee . . . As the responsibilities of the statutory body would include the protection of the public, it is considered that a contribution should be made from Government funds."

The British Medical Association argued as follows:

> "The Association would . . . support an approach to Government for reimbursement of all or some of that proportion of the cost of maintaining the Register which may be attributed to the public function, subject to satisfactorily safeguards that the content of the Register remained a matter for the independent statutory body, and it considers that the amount of the retention fee should then be adjusted accordingly."

(*b*) *Our broad view of the evidence*

427. We see no particular logic in the system of mixed finance proposed but, on the other hand, it seems a sensible compromise. Indeed, the call for financial assistance is understandable in a period when the cost of regulation is likely to grow. In chapter 2 we have recommended a rôle for the GMC in educational research, and if the GMC does commission research it will be involved in substantial extra expense. The fact that dual funding appears to command wide support among the profession is an important advantage. Accordingly, we recommend that the profession continue to provide the main financial support of the GMC, but that the possibility of a Government contribution to the cost of the GMC be examined. We expect that the majority of the profession would

not, for reasons of independence, wish the bulk of the GMC's finance to come from sources outside the profession. It was clear from its evidence that the British Medical Association assumed that "the major source of income will continue to be the profession itself". That view would no doubt be echoed by the Treasury.

(*c*) *The Government's contribution*

428. In considering ways in which a Government contribution might be made, we believe it would be impractical to attempt a clear division of the GMC's functions into those which are in the public interest and those which serve the profession. The most often-suggested area for a Government subsidy, medical registration, clearly has professional as well as public uses. It is just as much in the interests of doctors as the public for there to be a means of identifying qualified members of the profession. Since we do not believe that a Government contribution can be logically held to be more appropriate to one area of medical regulation than another, we do not recommend specific areas of the GMC's activities for a Government subsidy. If assistance from public funds proves generally acceptable, decisions on the amount and purposes of financial help are in our view matters for future consultation. We do, however, suggest in paragraph 430 one practical way in which the Government might assist.

(*d*) *The profession's contribution*

429. Turning to the way in which the profession should make its contribution, we comment straightaway that we see no alternative to an annual retention fee and therefore recommend its continuance. We do not consider that any body in times of inflation can guarantee its financial stability on the basis of once and for all registration fees. Certainly, this has been the lesson of the GMC's financial troubles in the last decade or so. We note that an annual payment is a condition of registration among many other professions. The list includes dentists, pharmacists, opticians, members of the professions supplementary to medicine, architects and solicitors. We sympathise with those members of the profession who have already paid a "life" fee but we do not consider it would be practicable—for the reasons of financial stability to which we have alluded—to exempt them from the fee. We expect that the GMC will in future years rely increasingly on annual payments. A further factor is relevant in this respect. The GMC is still heavily dependant on registration fees from overseas doctors, for example, in 1973 £154,570 out of a total income of £662,579 came from this source. By contrast, full and provisional registration fees from holders of U.K. and Irish qualifications amounted to only £66,640.[1] The former source of income may well decline in future years. Since it would seem fairer to spread any increased burden among all doctors, rather than transferring it to those at the beginning of their career, we consider that this will be a further factor in tipping the balance away from registration fees.

[1]These figures exclude income from annual retention fees paid by both British doctors and those from abroad with full registration.

(e) *The method of collection of the annual retention fee*

430. The GMC commented that the present system of collecting the annual retention fee has the following disadvantages:

> "There is no doubt that the collection of annual retention fees on the present basis is a costly procedure in relation to the sums collected—in 1972 £260,585 was collected at a cost of £60,189, roughly £1 per doctor. Like any other unpopular payment, the fee is regarded as a nuisance by many of the doctors concerned, each of whom must arrange to remit the fee. A further disadvantage of the present system is that it renders employing authorities in the National Health Service liable to uncertainty as to the continued registration of doctors in employment or contract with them since at any time a failure by a doctor to pay the fee may cause his registration to be terminated."

The GMC told us that it would be unlikely to object to the introduction of a system where retention fees were collected centrally by NHS employing authorities and remitted in bulk to the GMC. The GMC in that event would continue to collect the fee from those doctors not employed by the NHS. We are unable to offer a proper assessment, in the absence of a feasibility study, of the proposal's merits. The GMC recognised that the profession might not wish to see the fee's payment being so closely linked to the NHS. We hope that a discussion will be opened on this matter. The GMC envisaged that it might reimburse the NHS for the cost of collection. It may be that a suitable means of providing a subsidy for the GMC from public funds would be for the Government to make no charge for such a service. This would no doubt effect a large saving for the GMC.

(f) *Action on non-payment of the annual retention fee*

431. On the controversial subject of what action should be taken by the GMC where a retention fee is not paid, we note that most professions with annual fees remove the registration of those who do not pay. We note also the GMC's view, which we endorse, that it would be impracticable to seek to recover annual fees as a civil debt. What is chiefly urged against the removal of a doctor's name from the Register for not paying the annual fee is that, because removal prevents him earning his livelihood, the penalty is too severe. We feel bound to point out however that a doctor in such a position has the simple remedy of ending the penalty by paying his fee.[1] Clearly it would be an impossible situation for the GMC were payment of the fee in effect optional and we therefore recommend that doctors' registrations should continue to be withdrawn for not paying the annual fee provided that the GMC continues its present practice of allowing a period of grace and of sending first and final notices to doctors before removing their registration.

The adequacy of the GMC's future finances

432. Initially we were surprised at the size of the GMC's surplus in the last two years. The GMC's accounts for 1972 and 1973 showed surpluses of £127,777 and £270,770 respectively. We were told that the GMC considered this necessary for the following reasons: to pay off the bank overdraft and

[1]And generally an extra restoration fee of £10.

to regain a healthy balance of resources, to meet outstanding obligation to the superannuation fund in respect of past service of officers,[1] and to make allowance for continued inflation. About half the GMC's staff is housed in a building rented on advantageous terms but on a lease which will expire at the landlord's discretion between 1977 and 1983, and another quarter of the staff is in a building where the lease will expire in 1994. Clearly, therefore, the GMC is faced in the not too distant future with the need to acquire new premises, but the possibility is being explored of containing the resultant increased costs by stationing the majority of the staff outside central London. Whatever the long-term savings in costs, such a move would undoubtedly be expensive in the short term. The GMC estimates that there will again be a surplus of income over expenditure in 1974 but that this will be at a much lower level than in 1973. Inevitably, continuing inflation will have a serious effect on the GMC's finances, particularly on expenditure on staff.[2] The GMC's conclusion was that the position would change "from one of surplus to deficit within a few years, and any surpluses achieved in the meantime can be used to delay the time when an increase in the rates of fees will need to be considered".

433. In any event there can be no doubt that the new functions which we recommend for the GMC would add considerably to the cost of its operation. A number of areas can be identified where there would be extra expense. First, fitness to practise proceedings have traditionally been an expensive part of the GMC's responsibilities[3] and their cost would no doubt be substantially increased by our recommendation for a new rôle in relation to the sick doctor and for a unit to investigate complaints. Secondly, we have argued the need for a much wider scope in relation to the supervision of education. The GMC's activity in this field has been achieved comparatively inexpensively[4] up to the present, but that is not likely to continue particularly if, as we have mentioned, the GMC commissions educational research. Thirdly, the introduction of a system of assessment of individual overseas doctors will be expensive. The GMC hopes to recover the cost of assessment from such doctors but that may not prove possible. Finally, our recommendation that the GMC be placed under a general duty to promote high standards will, we envisage, open up further areas of GMC activity; for example, in relation to the issue of ethical guidance. It must therefore be recognised that implementation of our recommendations would put a further strain on the GMC's finances, and would hasten the increase of retention fees. To those concerned at such a prospect we comment as follows. One of the main criticisms of the present situation was that the GMC's powers were too limited in the face of developments in the field of medicine and certainly the establishment of a more active regulating body was more or less explicit in the great majority of the evidence we received Greater activity inevitably entails increased expenditure. We are firmly of the opinion that our proposals would establish a GMC equipped with appropriate responsibilities for present day medical practice. As a result, we believe that a GMC on the lines we recommend, albeit more expensive, would be better value for money than the present body can be given its restricted remit.

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[1]In 1973 £105,631 was used for this purpose.
[2]In 1973 about half of the GMC's expenditure was on staff.
[3]In 1973, direct expenditure on discipline amounted to £42,696 which itself was considerably lower than the figures in the two preceding years.
[4]In 1973, direct expenditure on education amounted to £13,312.

Our principal conclusions in Chapter 6

(27) The structure of the GMC should reflect its functions (paragraph 376).

(28) Once and for all registration fees which, from 1858 to 1970, were the GMC's principal source of income are inimical to sound finance in the present conditions of monetary inflation (paragraphs 421, 422 and 429).

(29) The GMC's financial affairs have not been mismanaged (paragraph 424).

(30) The present surpluses of the GMC are not unreasonable given the likely future calls on the GMC (paragraphs 432 and 433).

Our principal recommendations in Chapter 6

(78) The GMC should be independent (paragraph 377).

(79) The GMC should be predominantly professional (paragraphs 378–382).

(80) It would be undesirable to set up one regulating body for medical education and another for other aspects of regulation (paragraph 385).

(81) A General Council should be set up, all members of which should be subject to certain conditions of tenure (paragraphs 389–391, 407, 408 and 414).

(82) The General Council should have members on it elected by the single transferable vote electoral system by registered medical practitioners resident in the United Kingdom. There should be 10 more elected members on the General Council than all other members. Special arrangements should be made to ensure the nomination of young doctors for election. A small amount of information about candidates should be circulated with voting papers. Casual vacancies should be filled by a reserve system (paragraphs 392–401).

(83) The General Council should have members on it nominated by the principal medical educational bodies; the right of nomination to be settled after wide consultation (paragraphs 381, 402 and 405).

(84) The General Council should have 10 lay members on it (paragraphs 383, 403 and 404).

(85) The Republic of Ireland should not send members to the General Council (paragraph 406).

(86) An office of President of the GMC should be established (paragraph 410).

(87) An office of Chairman of the General Council should be established (paragraph 411).

(88) An Executive Committee should be established (paragraphs 412 and 413).

(89) Fitness to practise committees should be established (paragraph 415).

(90) An Education Committee should be established (paragraphs 416 and 417).

(91) The legislation dealing with the structure of the GMC should be simple and reasonably flexible (paragraph 419).

(92) The GMC should be financed principally by the medical profession but with an unhypothecated Government contribution (paragraphs 426 and 428).

(93) The medical profession's financial support of the GMC should be provided mainly by way of an annual fee for the retention of doctors' names on the Medical Register (paragraph 429).

(94) The possibility of collecting the annual retention fee through the NHS should be examined (paragraph 430).

(95) Doctors' registration should continue to be withdrawn for failing to pay the annual retention fee (paragraph 431).

THE IMPLEMENTATION OF OUR REPORT

We have provided a report which we believe to be relevant and appropriate to all parts of the United Kingdom. We received no evidence from any of the constituent parts of the United Kingdom to the effect that the regulation of the medical profession ought to be other than on a United Kingdom basis. We have no doubt that this basis is the right one—or at least that it would be retrograde, especially bearing in mind developments in Europe, to have different regulatory arrangements for the different countries of the United Kingdom. To say this is not to say that we believe in uniformity of method throughout the United Kingdom, still less that everything should be ordered from London. We believe that though the goal must be the same throughout the country, the means to that goal may differ. We held one of our meetings in Edinburgh and all that was discussed was relevant to both sides of the border. We have already become aware of the vigour of the Postgraduate Council in Scotland and there is no doubt that the contribution of the Council must be taken into account in the regulation of medical education in Scotland. That is one example of the sort of flexibility which we believe to be important. Indeed administrative flexibility seems to us to be generally desirable: we can see no reason why, as another example, fitness to practice committees should not meet outside London when their business made that more convenient, although if it were desired to arrange meetings in Scotland, any implications arising from the separate Scottish legal system would need to be considered.

We do not doubt that the responsible Ministers will wish to invite comments on our report very widely. It seems to us particularly important that the views and wishes of those in the constituent countries of the United Kingdom should be kept in mind, and we believe that a particular responsibility falls to the Secretaries of State for Scotland, for Wales and for Northern Ireland to ensure that they are.

We believe that the planning of the implementation of parts of our report dealing with functions should not wait upon the reformation of the structure of the GMC. Our report will take many years to implement and we think that the further delay on this account would be unacceptable. We hope we have suggested a system of regulation which will be appropriate at least for the rest of the century; that ought not to be the excuse for not getting on with the job.

(Signed) A W Merrison (Chairman)

John R Bennett

C M Clothier

Margaret Drabble

Catherine M Hall

N G C Hendry

Donald Irvine

Ian MacDonald

D C Marsh

Audrey M Prime

Ken Rawnsley

G A Smart

Jean Turner

Mary Warnock

W Brian Whowell

Brian Bridges (Secretary)

March 1975

DETAILS OF OUR WORK

We have held 27 meetings, three continuing over a weekend.

At our second meeting we decided to form three sub-committees to deal with education, registration (including overseas doctors and finance), and fitness to practise respectively, and these sub-committees did important preparatory work.

We saw nearly all the evidence submitted to us in its original form: only for a fairly small proportion of the large number of letters which we received from individuals in the summer of 1973 did we ask our Secretary to provide summaries. Otherwise all those submitting evidence to us are named in the list in this appendix.

We considered, not counting numerous drafts of our report, some 260 papers.

List of those who submitted evidence

Sir Godfrey Agnew
Association of Anaesthetists
Association of Hospital Management Committees
Association for the Study of Medical Education
Birmingham Regional Hospital Junior Staff
Dr C A Birt
British Association of Social Workers
British Dental Association
British Homoeopathic Association
British Medical Association* (Additional oral evidence was received from the Scottish Division of the BMA)
British Medical Association—Juniors Committee
British Medical Students Association
British Nutrition Foundation
British Optical Association
British Paediatric Association
British Postgraduate Medical Federation
Sir David Campbell
Dr David Cargill
Cavendish Medical Centre
Central Midwives Board
Christian Medical Fellowship
Lord Cohen of Birkenhead†
Committee of Vice-Chancellors and Principals of the United Kingdom Universities*
Community Council of Devon
Council for Postgraduate Medical Education in England and Wales*
County Councils Association
Dr J L Cranmer
Dr M G F Crowe
Mrs D M Dallas
Dr P Dawnay
Professor C E Dent

Department of Health and Social Security*
Divisions and Final Medical Committee of the London Hospital
Faculty of Anaesthetists
Faculty of Community Medicine
Faculty of Homoeopathy
Faculty of Ophthalmologists
Faculty of Radiologists
Fellowship for Freedom in Medicine
Mr R A Franklin
Mrs A D Gardiner
Mr R Gatehouse
General Dental Council
General Medical Council*
General Nursing Council
Dr M C Gill-Carey
Sir George Godber†
Dr Frank Gray
Group Consultants of the Swindon and District Hospital Management Committee
Group of general practitioners from the Oxford area
Dr John Bishop Harman
Dr J D J Havard
Dr Michael Hattwick
Home Office
Hospital Consultants and Specialists Association
Dr H N Hughes
Dr R B Hunter
Dr Allen Hutchinson
Institute of Health Service Administrators
Joint Committee of Ophthalmic Opticians
Joint Four
Junior Hospital Doctors Association*
Junior Staff Committee of Guys Hospital
Kings College Hospital Medical School
Dr R King†
Dr A J Lane
Dr Gareth Lloyd
London Hospital Medical College
Mr B M Male
Manchester Medical Students Representative Council
Dr M C Mason
Medical Defence Union*
Medical and Dental Defence Union of Scotland
Medical Practitioners Union*
Medical Protection Society*
Medical Research Council
Medical Womens Federation

Medicines Commission
MIND (National Association for Mental Health)
Ministry of Health and Social Services, Northern Ireland*
Dr P P Mortimer
National Association of Leagues of Hospital Friends
National Association for the Welfare of Children in Hospital
National Staff Committee (Nurses and Midwives)
National University of Ireland
Mrs R T Newmark
Sir Fraser Noble
Northern Ireland Council for Postgraduate Medical Education*
Dr Michael O'Donnell
Patients Association*
Mrs R M Perkins
Pharmaceutical Society of Great Britain
Dr K R D Porter†
Professor J M Potter
Dr D C Quantock
Registrars of the London Hospital
Mr Michael Reilly
Miss Anita R Reis
Mr P D Rohde
Dr A Rowe
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians, Edinburgh
Royal College of Physicians, Ireland
Royal College of Physicians, London
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons, Edinburgh
Royal College of Surgeons of England
Royal College of Surgeons in Ireland
St Thomas' Hospital Medical School
Scottish Council for Postgraduate Medical Education*
Scottish Home and Health Department*
Dr Myre Sim
Dr R G D Small
Society of Apothecaries
Society of Community Medicine
South West London and Surrey Local Medical Committee
Standing Conference of Colleges and Faculties in Scotland†
Dr T Stuart Black Kelly
Mr N Leigh Taylor

Christopher Terrell
Mr G C Tressider
University of Dublin
University Grants Committee
University of Liverpool
University of London
University of Manchester Medical School
University of Newcastle Faculty of Medicine
University of Southampton Faculty of Medicine
University of Wales
Dr R M Veall
Voluntary Euthanasia Society
Dr H J Wallace
Mr John Webb
Dr S D V Weller
Welsh Office*
Whole Time NHS Hospital Chaplains

*Denotes a submission of oral as well as written evidence.
†Denotes a submission of oral evidence only.

THE GMC'S CURRENT GUIDANCE ON CONDUCT WHICH MAY BRING A DOCTOR'S REGISTRATION INTO QUESTION

This appendix, which is self-explanatory, sets out the relevant part of the GMC's pamphlet on professional discipline, the so-called "blue booklet".

Convictions and Forms of Professional Misconduct which may lead to Disciplinary Proceedings

This part of the pamphlet sets out certain kinds of offences and of professional misconduct which have in the past led to disciplinary proceedings by the Council. The Disciplinary Committee and the Penal Cases Committee must proceed as judicial bodies. The pamphlet is thus not a complete code of professional ethics, nor can it specify all offences which may lead to disciplinary action.

The question whether any particular course of conduct amounts to serious professional misconduct, and the gravity of any conviction, are matters which fall to be determined by the Disciplinary Committee after considering the evidence in each individual case. Doctors desiring detailed advice on questions of professional conduct arising in particular circumstances are advised to consult a medical defence society or professional association who are prepared to give advice on such matters; it is rarely possible for the Council to give such advice, having regard to its judicial function.

The following paragraphs describe the more common types of offence or misconduct which have in the past been regarded as grounds for disciplinary proceedings. In most cases the gravity of the offence or misconduct will be readily apparent. In other cases however such as advertising, doctors may sometimes experience difficulty in deciding on the proper course in a particular set of circumstances, and the sections concerned have been amplified to indicate some of the principles which in the opinion of the Council are relevant in each field.

(i) Disregard of personal responsibilities to patients

In pursuance of the Council's primary duty to protect the public, disciplinary proceedings may be instituted in any case in which a doctor may appear to a serious extent to have disregarded his personal responsibility to his patients or to have neglected his professional duties, for example by failure to visit or to provide treatment for a patient. Many cases of this kind which are reported to the Council have already been investigated under the National Health Service machinery, but cases which have arisen in other ways may also be considered.

(ii) Abuse of alcohol

In the opinion of the Council convictions for drunkenness, or other offences arising from abuse of alcohol (such as driving a motor car when under the influence of drink), may indicate habits which may be a danger to a doctor's patients and are discreditable to the profession. After a first conviction for drunkenness a doctor may expect to receive a warning letter. Further convictions of such a nature may lead to an inquiry before the Disciplinary Committee at which all the convictions are liable to form the basis of the charge.

A doctor who treats patients or performs other professional duties while under the influence of drink is liable to disciplinary proceedings.

(iii) Abuse of controlled drugs

Disciplinary proceedings have been taken in cases in which a doctor has been found to have prescribed or supplied drugs of addiction or dependence otherwise than in the course of bona fide treatment.

Disciplinary proceedings have also been taken against doctors convicted of offences involving drugs which were committed in order to gratify the doctor's own addiction, or where a doctor has been convicted for driving or being in charge of a motor vehicle when under the influence of a drug or has treated patients when under the influence of drugs.

(iv) Termination of pregnancy

The Council regard as a serious matter the termination of pregnancy if done in circumstances which contravene the law. A criminal conviction in the British Isles for such an offence in itself affords ground for a charge before the Disciplinary Committee.

(v) Abuse of professional position in order to further an improper association or commit adultery

The Council has always taken a serious view of a doctor who *abuses his professional position* in order to further an improper association or to commit adultery with a person with whom he stands in professional relationship.

In an inquiry before the Disciplinary Committee, if a doctor is shown to have been found guilty of adultery in divorce proceedings in the High Court in the United Kingdom or the Republic of Ireland, such finding must, in accordance with the Medical Acts, be accepted by the Disciplinary Committee as conclusive evidence of the fact found.

(vi) Abuse of professional confidence

Disciplinary proceedings have been taken where it is alleged that a doctor has improperly disclosed information which was obtained in confidence from or about a patient.

(vii) Offences involving dishonesty, indecency or violence

Disciplinary proceedings have been instituted against doctors convicted of criminal deception (obtaining money or goods by false pretences), forgery, fraud, theft, indecent behaviour or assault. A particularly serious view is taken of such offences if committed in the course of a doctor's professional duties or against his patients or colleagues.

(viii) Advertising: Depreciation of other doctors

(1) The tradition that doctors should refrain from self-advertisement has long been accepted by the medical profession. In the opinion of the Council advertising is incompatible with the principles which should govern relations between members of a profession, and could be a source of danger to the public. A doctor who was successful at achieving publicity might not in fact be the most appropriate doctor for a patient to consult. In extreme cases advertising might raise hopes of a cure which then proved illusory.

(2) The professional offence of advertising may arise from the publication (in any form) of matter commending or drawing attention to the professional skill, knowledge, services, or qualifications of one or more doctors, when the doctor or doctors concerned have instigated or sanctioned such publication primarily or to a substantial extent for the purpose of obtaining patients or otherwise promoting their own professional advantage or financial benefit.

(3) Advertising may also be considered to occur if a doctor knowingly acquiesces in the publication (in any form) by other persons of matter which commends or draws attention to his own professional attainments or services, or if a doctor is associated with or employed by persons or organisations which advertise clinical or diagnostic

services connected with the practice of medicine. In determining in either set of circumstances whether professional misconduct has occurred, it is relevant to take into account

(a) the extent, nature and object of the publicity; and

(b) the question whether the arrangements had served to promote the doctor's own professional advantage or financial benefit.

(4) Advertising may arise from notices or announcements displayed, circulated, or made public by a doctor in connection with his own practice, if such notices or announcements materially exceed the limits customary in the profession. Questions of advertising may also arise in regard to reports or notices or notepaper issued by companies or organisations with which a doctor is associated or by which he is employed.

(5) The question of advertising may also arise in a number of other contexts, such as books by doctors, articles or letters or other items written by or about them in newspapers or magazines, and talks or appearances by doctors on broadcasting or television. In such cases the identification of a doctor need not *in itself* raise a question of advertising, but such a question may arise from the nature of the material printed or spoken (compare paragraph (6) below).

(6) In upholding a decision of the Disciplinary Committee the Judicial Committee of the Privy Council have stated some principles which, though enunciated in relation to books and articles, may be regarded as of general application:

> "The Disciplinary Committee were entitled to have regard to the content of the written material, the form in which it was written, and the selected media for its publication in forming conclusions as to what were the purposes which animated the writer. *The Committee were entitled to consider whether a desire to give information about a subject and to direct attention to such subject could have been achieved without directing attention to the personal and unique performances and abilities of the writer.*
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> * * * * *
>
> "On the one side of the line there might be a book or an article which is an exposition of a particular subject either written as a text-book for medical students or practitioners or written impersonally in order to give information to the general public. No exception could be taken to such publication. As an example on the other side of the line there might be a book or an article an essential theme of which is the praise and commendation of the skill and abilities of the writer himself with an express or implied suggestion that his successes in dealing with cases show that potential patients would do well to have recourse to him. That would be 'advertising'."

(7) The depreciation of the professional skill, knowledge, services or qualifications of another doctor or doctors may also lead to disciplinary proceedings.

(ix) Canvassing and related offences

Canvassing for the purpose of obtaining patients, whether done directly or through an agent, and association with or employment by persons or organisations which canvass, may lead to disciplinary proceedings.

Disciplinary proceedings may also result from other improper arrangements calculated to extend a doctor's practice. These include improper arrangements for the transfer of patients to a doctor's National Health Service list, without the knowledge and consent of the patients, or in a manner contrary to the National Health Service Regulations; and arrangements whereby doctors, whether singly or together with other doctors, have issued National Health Service prescriptions to persons who were being treated as private patients.

(x) Untrue or misleading certificates and other professional documents

Doctors are relied upon to issue certificates for a variety of purposes, for example of incapacity to work through illness or injury, on the assumption that the truth of the certificates can be accepted without question. In some cases the certificates are required to include a statement that a patient has been examined on a particular date.

Doctors are expected to exercise care in issuing certificates and kindred documents, and should not include in them statements which the doctor has not taken appropriate steps to verify. Any doctor who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper, renders himself liable to disciplinary proceedings.

(xi) Improper delegation of medical duties to unregistered persons and covering

A doctor who improperly delegates to a person who is not a registered medical practitioner duties or functions requiring the knowledge and skill of a medical practitioner is liable to disciplinary proceedings. This statement is not intended to restrict either (a) the proper training of medical and other health students or (b) the use of nurses, and of other persons who have been trained to perform specialised functions, to carry out treatment or procedures falling within the proper scope of such persons' skills. The doctor concerned should, however, retain ultimate responsibility for the management of the patient.

The Council has also regarded as calling for disciplinary action the arrangement known as covering, whereby a registered medical practitioner employs an unqualified medical assistant or otherwise enables a person who is not a registered medical practitioner to treat patients as though that person were a registered medical practioner.

(xii) Improper financial transactions

(1) Allegations that a doctor has improperly demanded or accepted fees from a patient under the National Health Service, contrary to the Regulations of the Service, may be regarded as raising a question of serious professional misconduct.

(2) Disciplinary proceedings may also result when a doctor knowingly and improperly obtains from an Executive Council or hospital authority any payment to which he was not entitled, or when a general practitioner under the National Health Service has improperly issued prescriptions to patients on his dispensing list.

(3) The Council has also viewed with concern, or regarded as a ground for disciplinary action (a) improperly prescribing drugs or appliances in which a doctor has a financial interest, (b) arrangements for fee-splitting, under which one doctor would receive part of a fee paid by a patient to another doctor, and (c) the commercialisation of a secret remedy.

Conclusion

It must be emphasised that the categories of misconduct described above cannot be regarded as exhaustive, since from time to time with changing circumstances the Council's attention is drawn to new forms of professional misconduct. Any abuse by a doctor of any of the privileges and opportunities afforded to him, or any grave dereliction of professional duty or serious breach of medical ethics, may give rise to a charge of serious professional misconduct.

THE GMC'S PROCEDURE IN DISCIPLINARY CASES

The evidence we received showed considerable misunderstanding of the GMC's disciplinary procedure. We therefore asked the GMC to provide a description of the procedure. This Appendix contains that description.

Introduction

1. The GMC's disciplinary procedure is regulated first by sections 32–39 of the Medical Act 1956 and sections 13–16 of the Medical Act 1969, then in considerable detail by the Disciplinary Committee (Procedure) Rules 1970 and finally by the Legal Assessor Rules[1] made by the Lord Chancellor under what is now section 38 of the Medical Act 1956.

2. The Disciplinary Committee (Procedure) Rules are summarised in paragraphs 11–32 below. The Rules are made under section 37 of the 1956 Act which requires the Committee to make Rules "as to the procedure to be followed and the rules of evidence to be observed in proceedings before the Committee" and in particular in relation to a number of other matters. The same section requires the Disciplinary Committee, before making such Rules, to "consult with such bodies of persons representing medical practitioners . . . as appear to the Committee requisite to be consulted". It also provides that the Rules shall not come into force until approved by order of the Privy Council and the Privy Council may approve such Rules either as submitted to them or subject to such modifications as appear to them requisite. The provisions of the Rules are therefore effectively influenced by the Privy Council. The current Rules were approved by an Order of the Privy Council made in April, 1970[2].

Legal Assessors; The Legal Assessor Rules; Other Rules regulating Evidence

3. Section 38 of the Medical Act 1956 requires the Disciplinary Committee always to sit with a Legal Assessor who shall be "a barrister, advocate or solicitor of not less than 10 years' standing". Rules made under the section by the Lord Chancellor provide that it shall be the duty of the Legal Assessor to be present at all proceedings before the Disciplinary Committee and to advise the Committee on questions of law arising therein. In particular it shall be the duty of the Legal Assessor to inform the Committee forthwith of any irregularity in the conduct of proceedings before the Committee which may come to his knowledge and to advise them *of his own motion* where it appears to him that but for such advice there is a possibility of a mistake of law being made. The Rules also require the advice of a Legal Assessor to be tendered to the Committee in the presence of every party: advice given in camera while the Committee are deliberating must be repeated immediately afterwards to the parties and also put in writing and given to them. If on any occasion the Committee do not accept the advice of the Legal Assessor a record must be made of the question referred to him, of the advice given, and of the refusal to accept it, together with the reasons for such refusal, and a copy of the record given to every party.

4. Rule 47 of the Procedure Rules governs the admission of evidence before the Disciplinary Committee. Among other things the Rule provides that where any fact or matter is tendered as evidence which would not be admissible as such if the proceedings were criminal proceedings in England, the Committee shall not receive it unless after consultation with the Legal Assessor they are satisfied that their duty of making due inquiry into the case before them makes its reception desirable. The Disciplinary Committee has under the Medical Acts power to compel the attendance of witnesses by subpoena and to require evidence to be given upon oath.

5. Although there is no statutory requirement for the Penal Cases Committee to sit with a Legal Assessor it has in practice for many years invariably done so.

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[1]SI 1951 No. 1918.

[2]SI 1970 No. 596.

The Disciplinary Committee, the Penal Cases Committee and the President or authorised member

6. As appears from the account below disciplinary cases may be considered by the President or other authorised member, by the Penal Cases Committee and by the Disciplinary Committee. The composition of these two Committees is briefly described below, as are the functions of the President or authorised member in relation to disciplinary cases.

The Disciplinary Committee

7. The composition of this Committee is fixed by section 32 of and the Fourth Schedule to the 1956 Act. These provide that it shall consist of the President and 18 other members of the Council. Of the 18 members at least six shall be elected members and at least two lay members. Not more than nine members of the Committee (including at least two elected members and at least one lay member) hear any case unless it appears that there are circumstances requiring the presence of a greater number of members. Since 1971 all cases have been heard by nine members or fewer. The quorum of the Committee is five. Under the Act the President acts as Chairman of the Committee if present. In his absence the Committee choose another member as Chairman.

8. The Committee is elected annually by the Council from among its own members. To secure some measure of rotation one-third of the members who are neither elected members nor lay members of the Committee retire each year. A similar arrangement was formerly followed in relation to the elected members, but was recently discontinued because the number of elected members on the Council (eleven) is so small that it was felt undesirable to disqualify any of them by this means for sitting on the Disciplinary Committee.

9. No member who has considered a case as a member of the Penal Cases Committee is allowed to adjudicate on that case if it comes before the Disciplinary Committee. Because of this the Council decided that no member should serve concurrently on the Penal Cases Committee and Disciplinary Committee; and further that at least a year must elapse after any member who has served on the Penal Cases Committee may serve on the Disciplinary Committee. The purpose of this arrangement was to avoid members sitting on the Disciplinary Committee who would not be qualified to adjudicate on some of the cases coming before it.

10. The Disciplinary Committee normally meets three times a year, for about two weeks on each occasion. Its meetings are held about seven weeks after a meeting of the Penal Cases Committee. Respondent doctors are required to be given at least four weeks' notice of any inquiry.

The Penal Cases Committee

11. The composition of this is fixed by the First Schedule to the Procedure Rules. Apart from the President it consists of five members of whom one must be a lay member and one must be an elected member of the Council. The other three medical members may be elected members of the Council but must be drawn one each from the English, Scottish and Irish Branch Councils respectively. The President if present at any meeting acts as Chairman. In his absence the Committee choose another member as Chairman.

The President or authorised member

12. Preliminary decisions on disciplinary cases are taken by the President or by another member authorised by the President to act on his behalf. The Medical Acts and the Procedure Rules were based upon the assumption that the President would chair both the Disciplinary Committee and the Penal Cases Committee and also deal with the initial consideration of cases, but the Procedure Rules empower the President to authorise another member of the Council to act on his behalf. In

November, 1973, the Council decided that it was undesirable for the President both to chair the Disciplinary Committee and also to chair the Penal Cases Committee and deal with the preliminary stages. Since that time the President has chaired the Disciplinary Committee and has authorised to deal with the preliminary stages of the work another member of the Council who has also been chosen as Chairman of the Penal Cases Committee. The President has indicated that after a period he will exchange roles. Another member or members of the Council will then act as Chairman of the Disciplinary Committee.

The Rules of Procedure in disciplinary cases: the preliminary stages

13. When the Registrar receives a complaint or information in writing from any Body or person from which it appears (1) that a doctor has been convicted in the British Isles of a criminal offence or (2) that a question arises whether the conduct of a doctor constitutes serious professional misconduct, the Registrar is required to submit the matter to the President or other authorised member. This requirement does not apply to convictions of offences under the Road Traffic Acts which do not involve abuse of drink or drugs. Other convictions are in practice referred automatically to the Penal Cases Committee except that if the conviction was reported to the Council by the police the doctor is told and may if he wishes offer observations on the conviction for consideration by the Penal Cases Committee.

14. The procedure for considering allegations of professional misconduct is more complicated. If the allegations come from a private complainant they must be supported by one or more statutory declarations—that is to say statements declared before an authorised person in a form prescribed by the Statutory Declarations Act. Information forwarded by a "person acting in a public capacity" is exempt from this requirement. Such persons include officials of Government Departments, public authorities, officers attached to a court and the Solicitor to the Council.

15. After considering the complaint or information the President (or other authorised member) may decide that the matter need not proceed further. But if he considers that a question arises whether the doctor has committed serious professional misconduct and that the evidence justifies further action, he must direct the Registrar to write to the doctor notifying him of the receipt of the complaint or information, stating the matters which appear to raise a question whether the doctor has committed serious professional misconduct, forwarding copies of any statutory declarations received, informing the doctor of the date of the next meeting of the Penal Cases Committee and inviting the doctor to submit any explanation which he may have to offer. The case may then be referred to the Penal Cases Committee.

Consideration by the Penal Cases Committee

16. The Penal Cases Committee meet in private. On each case they consider the documentary evidence received by the Council (or such of it as is relevant) and any explanation offered by the doctor. The Committee may adjourn consideration of the case for further investigations or to give the doctor an opportunity to submit further evidence or explanations. Ultimately, and in most cases immediately, the Committee must decide either to refer the case to the Disciplinary Committee for inquiry or that no inquiry shall be held. In the latter case the doctor is informed of the decision in such terms as the Penal Cases Committee may direct. This may mean that a "warning letter" is sent to the doctor.

17. If the Penal Cases Committee decide not to refer for inquiry an allegation of professional misconduct that matter cannot subsequently be re-opened. But a decision not to refer for inquiry a conviction does not preclude the inclusion of that conviction in a charge if at a later date, following the notification of another conviction or a new allegation of professional misconduct, an inquiry by the Disciplinary Committee is considered necessary.

Preliminaries to a hearing by the Disciplinary Committee

18. "As soon as may be" after a case has been referred to the Disciplinary Committee the Council's Solicitor is required to send a "notice of inquiry" to the doctor at his registered address (or to his last known or any other address if it appears that a letter so addressed is more likely to reach he doctor). The notice of inquiry sets out in the form of a charge or charges the matters into which the inquiry will be held and informs the doctor of the time and place. The doctor is sent a copy of the Rules of Procedure. If there is a complainant who wishes to present the case before the Disciplinary Committee he is also informed. The hearing may not be held less than 28 days after the notice of inquiry is posted unless the doctor agrees to a shorter period.

19. The President or authorised member has power to postpone an inquiry: this not infrequently happens at the request of the doctor. The President also has power to cancel a proposed inquiry if information emerges from which "it appears to the President that the inquiry should not be held" but he must first consult the Penal Cases Committee and secure their agreement.

Proceedings before the Disciplinary Committee

20. Where the doctor does not appear the Solicitor is required to satisfy the Committee that the notice of inquiry has been received by the practitioner. If it does not appear to have been so received, the Committee may nevertheless proceed with the inquiry if they think fit on being satisfied that all reasonable efforts have been made to serve the notice of inquiry.

21. The respondent doctor is entitled, but cannot be compelled, to attend the inquiry. He is entitled to be legally represented and this is normally arranged by the doctor's medical defence society. At the opening of the inquiry the doctor may challenge the terms of the charge on points of law.

22. Under the Rules of Procedure and the Act cases must be heard by the Disciplinary Committee in public except where "in the interests of justice or for any other special reason it appears to the Committee that the public should be excluded from any proceedings or part thereof". The parties to a case (that is to say the doctor, his lawyers and the Council's Solicitor or complainant) cannot be excluded except while the Committee are deliberating on their findings. At the conclusion of a case the Committee's decision must be announced to the doctor in public.

Cases relating to convictions

23. In cases of convictions the Council's Solicitor adduces evidence of the fact of the conviction and the conviction is normally then admitted by the doctor. The Disciplinary Committee must accept a conviction as conclusive evidence that the doctor was guilty of the offence of which he was convicted. The Solicitor will normally call some evidence as to the circumstances leading up to the conviction and the doctor will call evidence in mitigation. The great majority of cases of conviction considered by the Disciplinary Committee relate either to offences against the laws and regulations controlling drugs or to offences involving abuse of alcohol (for example, drunken driving).

24. At the conclusion of the doctor's case the Committee then decides whether to admonish the doctor and conclude the case, or to postpone judgment, or to suspend the doctor's registration for a period not exceeding 12 months or to direct erasure. If the Committee decide to suspend or to erase they also have power to order that the doctor's registration should be suspended immediately, "if satisfied that to do so is necessary for the protection of members of the public or would be in the best interests of the doctor". Unless the Committee order immediate suspension, their decision will not take effect for 28 days during which the doctor may give notice of appeal to the Judicial Committee of the Privy Council. If he does give notice of appeal the Disciplinary Committee's decision does not take effect unless and until the appeal is dismissed or withdrawn.

Cases relating to conduct

25. Unless there is a private complainant who wishes to present his complaint the Council's Solicitor calls evidence in support of any charge which is not admitted by the doctor. This evidence is open to challenge by cross-examination, and the doctor may produce evidence to rebut the evidence called against him.

26. Unless the doctor chooses to admit at the opening of the inquiry all the facts alleged in any charge or charges against him evidence is called in support of the charges. This evidence is cross-examined on behalf of the doctor. At the conclusion of the case against the doctor he may submit either that no sufficient evidence has been adduced upon which the Committee could find that the facts alleged in the charge have been proved or that the facts of which evidence has been adduced are insufficient to support a finding of serious professional misconduct. If neither of these submissions is upheld, the doctor may then adduce evidence, both his own and that of other witnesses, in answer to the charge. The Council's Solicitor with the leave of the Committee may adduce evidence to rebut such evidence. After this the Solicitor addresses the Committee and the doctor (or more usually his lawyer) will then address the Committee. The Committee then have to decide which if any of the facts alleged in the charge have been proved to their satisfaction: they may also at that stage decide that such facts as have been proved would be insufficient to support a finding of serious professional misconduct.

27. The Committee's decisions on these matters are then announced to the doctor and if any charge is found not proved or the facts proved are found insufficient to support a finding of serious professional misconduct, the Committee record a finding that the practitioner is not guilty of serious professional misconduct in respect of those matters.

28. The inquiry then moves to its second stage which is to determine whether any of the facts proved constitute serious professional misconduct and if so what action shall be taken. During this stage the Council's Solicitor may call further evidence as to the circumstances leading up to the facts or as to the character and previous history of the doctor: and the doctor or his lawyer may address the Committee by way of mitigation and adduce evidence as to his character and previous history. If at the outset of the inquiry the doctor has admitted the facts alleged in the charge the Committee will then move directly to the second stage.

29. At the conclusion of the second stage it is open to the Committee to postpone judgment on whether the facts amount to serious professional misconduct or, if it judges that they do amount to serious professional misconduct, to postpone a finding whether to order suspension or erasure. If they judge him guilty of serious professional misconduct, they may either admonish him and conclude the case, or decide to order suspension for a period not exceeding 12 months or to direct erasure. If they order suspension or erasure they may order immediate suspension as in cases of conviction.

Procedure after postponement of judgment or finding or suspension of registration

30. In a substantial proportion of the cases dealt with by the Disciplinary Committee, and particularly those arising from a doctor's dependence on alcohol or other drugs, the Committee postpone their judgment or finding or, if they decide to suspend registration, intimate that they will, at a meeting to be held before the end of the period of suspension, resume consideration of the case with a view to determining whether or not they should then direct that the period of suspension be extended or that the name of the doctor should be erased from the Register. Commonly in these cases the doctor is required to furnish the names of referees to whom the Committee may apply for information, to be given confidentially, as to the doctor's habits and conduct since the time of the original hearing. The Committee may also ask the doctor to arrange for a psychiatric report to be given to the Committee on him.

31. In all these cases the Council's Solicitor is required to give the doctor six weeks' notice of the day when the hearing will be resumed and to invite him to forward the names of referees. At the resumed hearing the Solicitor recalls how the case stands and may adduce evidence as to habits and conduct of the doctor since the earlier hearing (including evidence of any new conviction if one has occurred). The doctor (or his lawyer) may then address the Committee and call evidence on his behalf. The Committee then resume consideration of the case at the point at which they had previously reached. The Committee may decide again to postpone judgment or finding but if not decide whether to conclude the case or order suspension or erasure. If the doctor has behaved satisfactorily in the intervening period, the case is normally concluded. In a case where a period of suspension was originally ordered, the Committee will consider whether to allow the suspension to end or whether to extend the period of suspension or order erasure.

Applications for restoration following disciplinary erasure

32. Where the Disciplinary Committee have ordered the erasure of a name from the Register the doctor may make application for restoration when 10 months have elapsed since the order took effect. This normally permits his application to be considered a year after the hearing at which erasure was ordered. The doctor is required to support his application by a statutory declaration and to provide formal evidence of identity and good character. At the hearing the Solicitor will recall the circumstances in which the applicant's name was erased from the Register and may adduce evidence as to the conduct of the applicant since that time. The applicant may address the Committee and adduce evidence as to his conduct since his name was erased. The Committee will then decide either to restore the name or to refuse the application. In the latter case a further application may be made when a further period of 10 months has elapsed.

FURTHER CONTROLS ON DOCTORS' FITNESS TO PRACTISE

General

1. The purpose of this appendix is to outline a number of ways other than the GMC procedures in which doctors' actions are subject to control, and the arrangements for doctors' failings in these fields to be notified to the GMC. The appendix is in three parts. Part A describes NHS control procedures, Part B outlines the notification of doctors' convictions to the GMC, and Part C explains the control over the possession and supply by doctors of dangerous or otherwise harmful drugs.

PART A: NHS CONTROL PROCEDURES

Introduction

2. This part of the appendix describes the situation in England. There are slight differences in the procedures in operation in Wales and more substantial differences in those relating to Northern Ireland and Scotland. The differences are not however sufficiently important to affect the purpose of the appendix and are not therefore detailed in the following paragraphs.

I: General Practitioners

General practitioners: complaints procedure

(a) General

3. Family Practitioner Committees the authorities responsible for administering the family practitioner services, unlike other health authorities, do not provide services directly through employees. Instead, they make arrangements with practitioners—doctors, dentists, chemists and opticians—who undertake to provide general medical, general dental, pharmaceutical or general ophthalmic services. The practitioners' terms of service are laid down in regulations made by the Secretary of State under the relevant sections of the National Health Service Acts. The relationship between the practitioners and the Family Practitioner Committees is thus in effect contractual. The service committee procedure provides a means, agreed with the profession, of ensuring that practitioners fulfil their contractual obligations. It is governed by the National Health Service (Service Committees and Tribunal) Regulations 1974 (as amended).

4. Under these Regulations, each Family Practitioner Committee sets up special committees, known as service committees, to carry out investigations in accordance with the provisions of the Regulations. An investigation may be undertaken as a result of a complaint made by a patient or some other person acting on his behalf, or at the instance of the Family Practitioner Committee.

(b) Composition of service committees

5. Each Family Practitioner Committee appoints five service committees, these corresponding to the four professions together with a joint services committee. With the exception of the last named committee the Regulations aim at securing that each of the committees, when carrying out investigations, has an equal number of members appointed by and from the lay members of the Committee and professional members appointed by the local professional committee, together with a lay chairman.

(c) Scope of service committees

6. The scope of a service committee is limited under the Regulations almost wholly to determining whether a practitioner has complied with the terms of service which form part of his contract with the Family Practitioner Committee. The terms of service for doctors, for example, require a doctor, among other things, to give his patients all necessary and appropriate personal medical services of the type usually

provided by general medical practitioners. A service committee cannot investigate allegations of matters unconnected with the NHS contract nor can it consider a claim for damages arising out of alleged negligence. The extent to which a patient may gain financially from the investigation is limited to the recovery of any statutory charge he may have paid for unsatisfactory treatment or of certain expenses he may have incurred as a result of the practitioner failing to provide the services he should have done.

(*d*) *Action of service committees*

7. A complaint which is formally investigated under the Regulations can be considered with or without the aid of a hearing. A service committee need not have a hearing of a complaint if it considers that the complaint is frivolous or vexatious or that it does not involve a breach of the terms of service. Where a committee does have a hearing, the practitioner, the complainant and any witnesses are invited to be present. The parties may not be represented by counsel, solicitor or other paid advocate but may be assisted by such persons. They may be represented by persons not in these categories. The proceedings are held in private. Evidence is given in the presence of both parties, and is subject to cross-examination. A service committee reports to the Family Practitioner Committee, stating such relevant facts as appear to have been established, the inferences which may be drawn from them,[1] and recommending what action, if any, should be taken.

8. Where a practitioner is found in breach of his terms of service, the recommendations normally consist of one or more of the following:

(*a*) no further action (generally where the breach is trivial);

(*b*) a warning;

(*c*) the recovery from the practitioner, and repayment to the person concerned, of expenses reasonably and necessarily incurred by such person owing to the failure to comply with the terms of service;

(*d*) the withholding of an amount from the respondent's remuneration.

(*e*) *Action of Family Practitioner Committees*

9. The Family Practitioner Committee arrives at a decision based on the investigation carried out by the service committee. Copies of the service committee report are sent to the parties to the complaint and they are informed of the right of appeal described in the next paragraph.

(*f*) *Appeal to the Secretary of State*

10. Against an adverse decision of the Family Practitioner Committee, the practitioner or complainant has a right to appeal, within one month, to the Secretary of State who may determine the appeal either on the papers or after an oral hearing.

11. If the Family Practitioner Committee proposes a withholding from remuneration, a practitioner is automatically allowed, if he wants it, an oral hearing of his appeal. A hearing is also held where there is a conflict of evidence which cannot be resolved on the papers. The hearing is held in camera and is conducted by a legally qualified chairman from the Department of Health and Social Security and two members of the same profession as the practitioner, one of whom is invariably an officer of the Department of Health and Social Security. Parties to the appeal are entitled to be legally represented at hearings.

12. If the Family Practitioner Committee has proposed a withholding of remuneration, the practitioner may, instead of appealing, make representations, either orally or in writing, to the Secretary of State against such a proposal. This also applies where the Secretary of State is proposing to direct a higher withholding

[1]That is, the breaches of the terms of service, if any, which have been committed.

than that, if any, recommended by the Family Practitioner Committee. In such instances, the practitioner cannot dispute the facts found by the service committee or the finding of a breach, but directs his arguments solely towards the proposed withholding. The procedure followed at hearings of representations is very similar to that followed at hearings of appeals.

(*g*) *Medical and Dental Advisory Committees*

13. Where the Secretary of State is proposing to withhold an amount from a respondent's remuneration and the case is a medical or dental case involving breaches of the terms of service of a clinical nature, the Secretary of State must consult his Medical or Dental Advisory Committee before directing the withholding. Both the Committees have six members drawn from the profession of the person concerned; three from inside and three from outside the Department of Health and Social Security.

(*h*) *Decision of the Secretary of State*

14. The Secretary of State, after considering all the circumstances of each case gives a decision. In the case of an appeal, a reasoned decision is given. The decision is final and the matter cannot be re-opened under the Regulations.

General practitioners: National Health Service Tribunal

15. The NHS Tribunal considers representations that the continued inclusion of a person on any Family Practitioner Committee list would be prejudicial to the efficiency of the service in which that person is participating. The Tribunal deals with dentists, pharmacists and various categories of opticians as well as general medical practitioners. Any person or body may make representations to the Tribunal but in practice they are almost invariably made by Family Practitioner Committees. The Tribunal meets rarely.[1]

16. The Chairman of the Tribunal must be a practising barrister or solicitor of not less than 10 years' standing, and there are two other members. One member is appointed by the Secretary of State after consultation. The other member is appointed by the Secretary of State from a panel of medical practitioners, dental practitioners, pharmacists, ophthalmic medical practitioners, ophthalmic opticians or dispensing opticians as appropriate. Each panel has not more than six names, and appointments to the panels are made by the Secretary of State after consultation with representative professional associations.

17. The procedure at the inquiry is at the discretion of the Tribunal, but normally the hearing is in camera. The practitioner, chemist or optician has the right of legal representation; evidence is taken on oath; and witnesses may be subpoenaed. Where the Tribunal decides that the general medical practitioner, or member of the other professions covered by the Tribunal, should no longer be included in any Family Practitioner Committee list it normally makes a direction to that effect in two parts: first, specifying those Family Practitioner Committees with which the practitioner had arranged to provide services and, secondly, applying the bar to all other Family Practitioner Committees. The Tribunal in effect provides a means of preventing a general practitioner to whom a direction applies from providing general medical services within the NHS elsewhere in the country. Costs may be awarded against either party to the proceedings before the Tribunal. The Tribunal reports its findings and decision to the parties and to the Secretary of State. Where a person's name is removed from a Family Practitioner Committee's list the Tribunal's decision is published.

18. The Tribunal's decision is final if it is in favour of the practitioner, but practitioners have the right of appeal to the Secretary of State against an adverse decision. The appeal is decided by the Secretary of State in the light of the report

[1]Twice in 1972, for example.

of a hearing by persons he appoints for the purpose; that is, a chairman who is a lawyer, assisted by a member of the same profession as the appellant. Under the Tribunals and Inquiries Act 1971 there is an additional right of appeal to the High Court on a point of law. The Tribunal or the Secretary of State may also consider an application from a practitioner for a direction that he should no longer be disqualified for inclusion in any list or lists to which an existing direction by the Tribunal or Secretary of State relates.

The procedure for suspending general practitioners from a Family Practitioner Committee's list on account of mental or physical disability

19. The current terms of service of general medical practitioners, which form Schedule 1 of the NHS (General Medical and Pharmaceutical Services) Regulations 1974, include the following paragraphs:

"*Continued absence or disability of doctor*

40. Where it appears to the Committee after consultation with the Local Medical Committee, that a doctor is incapable of adequately carrying out his obligations under the terms of service because of physical or mental disability, he may be required by the Committee to supply to the Local Medical Committee for action under regulation 34 a medical report by a suitably qualified doctor as to such aspects of his health as the Local Medical Committee may specify.

41. Where a Committee is satisfied—

(*a*) after receiving a report under paragraph 40 from the Local Medical Committee that because of physical or mental disability, or

(*b*) after consulting the Local Medical Committee, that because of continued absence,

a doctor's obligations under the terms of service are not being adequately carried out, it may after consulting the Local Medical Committee and with the consent of the Secretary of State—

(i) make arrangements for securing the treatment of persons on the list of that doctor; or

(ii) give notice to the persons on his list that the doctor is for the time being in its opinion unable to carry out his obligations under the terms of service.

42. To enable the Committee to decide whether any arrangements made under paragraph 41(i) should be terminated, or where notice has been given under paragraph 41(ii) whether a further notice should be given to the persons on the doctor's list that he is now, in the Committee's opinion, able to carry out his obligations under the terms of service, a doctor may be required by the Committee, after consultation with the Local Medical Committee, to supply to the Local Medical Committee for action under regulation 34 a medical report by a suitably qualified doctor as to such aspects of his health as the Local Medical Committee may specify."

20. Regulation 34 of the above quoted Regulations, referred to in the above extracts from the terms of service, reads as follows:

"*Reports by Local Medical Committees*

34. Where under paragraphs 40 or 42 of the terms of service a doctor is required by the Committee to supply a report to the Local Medical Committee, the Local Medical Committee shall consider any report so supplied and make a report to the Committee as to the doctor's fitness for carrying out his obligations under the terms of service."

21. Before 1st April 1973 a similar procedure was in operation, except that Executive Councils had no power to require a doctor to provide a medical report.

General practitioners: investigation by local professional committees

22. Among the categories of investigations by local professional committees are the following:

(*a*) investigation by Local Medical Committees of excessive prescribing by doctors;

(*b*) investigation by Local Medical Committees of practitioners' record keeping;

(*c*) investigation by Local Medical Committees of certification for the purpose of certain social security payments;

(*d*) investigation by Local Medical Committees of whether a substance prescribed by a doctor was a drug, and recovery of the cost thereof;

(*e*) investigation by any local professional committee of a complaint made by a member of the profession against another member.

23. The number of formal investigations carried out by such committees is small. For example, in 1972 there were only two completed investigations carried out under category (*a*) in paragraph 22 above. The procedure followed in each type of investigation, with the exception of the last named, is very similar and consists of an investigation by the local professional committee and a right of appeal to referees appointed by the Secretary of State. The Local Medical Committee may decide that the matter can be resolved on the basis of the written evidence, or its members can, if they wish, arrange a hearing. The practitioner is entitled to be present at the hearing with a representative if he so desires, and a representative of the referring body[1] is also entitled to be present. Following the investigation the Local Medical Committee draws up a report, setting out its findings and recommendations, if any, and copies are sent to the practitioner, the Secretary of State and, where applicable, the Family Practitioner Committee. If the practitioner is dissatisfied with the decision of the Local Medical Committee, he may appeal to the Secretary of State within one month. If the Secretary of State is dissatisfied with the decision of the Local Medical Committee, he may refer the matter to referees within the same period. In either case, the Secretary of State appoints up to three persons, or referees, to hear and determine the appeal or reference. Where the case against a practitioner is found proven, if necessary following an appeal or reference, the Secretary of State may make a direction in accordance with the relevant Regulation. In a proven case of excessive prescribing, for example, the direction would take the form of a withholding from the doctor's remuneration.

General practitioners: arrangements for informal resolution of complaints

24. An informal procedure for considering complaints by patients was introduced, in respect of doctors, in April 1968, following negotiations between the Minister of Health and the medical profession. The profession had represented that the service committee procedure was unduly cumbersome for dealing with unimportant complaints. This point was accepted and the informal procedure was accordingly introduced to deal with such complaints.

25. Each Executive Council was asked—not all chose to do so, however—to appoint one of its lay members, to operate the procedure. His task was to look at all complaints[2] to consider whether it might be possible for him to effect a reconciliation between the complainant and the doctor without reference to the formal service committee procedure. The informal procedure does not prejudice the right of either the complainant or the doctor to have the matter considered formally, if he so wishes. Either party can refuse to have a complaint dealt with informally or can insist that it is investigated formally if he is not satisfied with the outcome of the informal procedure. There are also safeguards against the position of either being prejudiced in a formal investigation by a preceding informal inquiry.

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[1]Usually the Secretary of State makes the reference.

[2]Other than those minor grievances which could be settled administratively.

Hospital service: complaints

26. The main memorandum, HM(66)15, dealing with this matter was issued in 1966 by the Department of Health and Social Security and is reproduced below.

"*Summary.* This memorandum sets out the procedure for enquiring into complaints made by, or on behalf of, patients.

1. The Minister appreciates the care given by hospital authorities to the consideration of complaints made by, or on behalf of, patients. Information provided by Hospital Boards shows that in general authorities realise the importance of ensuring that all such complaints are sympathetically received and fairly and speedily dealt with. There is virtue, however, in adherence to a well recognised procedure; and the Minister thinks it appropriate that there should be general guidance about what this should be.

2. Two general principles apply to all that follows. First, all complaints should be dealt with as promptly as the circumstances require. Secondly, not only should complaints be investigated, but it should be made evident to complainants that their complaints have been fully and fairly considered.

3. Complaints vary from those arising merely from misunderstanding or ignorance of hospital procedures, which often need only a word of explanation from an appropriate member of the staff, to those calling for formal enquiry by or on behalf of the hospital authority. The procedure outlined in paragraph 7 is therefore designed to cover complaints ranging from the relatively minor to the most serious, and the Minister hopes that this procedure will be adopted for all complaints which cannot be dealt with on the spot, subject to possible variations in different types of hospital (for example, special arrangements may often be needed in psychiatric hospitals), and to what is said in paragraph 4.

4. The guidance in RHB(51)80 and HM(61)112 should continue to be applied in the serious disciplinary cases with which those memoranda deal. Also the guidance in HM(55)66 should continue to be applied when there is an accident in hospital; statements and reports should be obtained in the manner outlined in that memorandum, and they will be legally privileged documents.

5. Where Court proceedings in relation to the subject matter of a complaint have been started or are thought likely, hospital authorities should consult their legal advisers before dealing or continuing to deal with the complaint. Whenever investigation of a complaint may point to action to ensure the proper running of the hospital, however, the authority will wish to take such action without delay, and legal proceedings or the likelihood of legal proceedings should not deter the authority from themselves carrying out whatever investigation is needed to this end.

6. Hospital Management Committees should consult the Regional Hospital Board at an early stage in all cases which appear serious or involve wider issues than the day-to-day administration of the hospital.

7. Subject to these general observations, the following procedure should apply:—

(i) Complaints made orally which cannot be dealt with forthwith to the complainant's satisfaction should be reported for consideration to a senior member of the staff in the department to which they relate, who should make a brief note of the complaint and of the circumstances. Appropriate action should be taken, and the complainant informed of the result. Where the complainant is not satisfied, he should be told that he can take his complaint to a higher level, and if he decides to

do so he should be asked to put it in writing or, if necessary and if he agrees, it can be put in writing at his dictation by a member of the staff and signed by him. The complainant should be told to whom the complaint should be addressed.

(ii) Any written complaint should be seen by the Secretary of the Board of Governors or Hospital Management Committee or by a senior member of his staff designated by him, and the action taken or to be taken on the complaint should be agreed by him after consultation with the Head of the Department(s) concerned.

(iii) Any complaints which cannot be satisfactorily dealt with by officers in this way should be reported to the Board of Governors or Hospital Management Committee or to an appropriate committee for decision as to further action. Where the Board or Committee consider that further investigation is necessary, they may decide:

(*a*) to appoint one or more members of the authority to make an investigation and report back; (Alternatively, a Hospital Management Committee may ask the Regional Hospital Board—or the Board may decide, following a reference under paragraph 6—to appoint one or more of its members to make such an investigation) in such a case, where it might assist the investigation, or where he so desires, the complainant, accompanied by a friend if he wishes, should be present and allowed to be heard; as also should the person complained against, if he wishes;

(*b*) in the small number of cases which are so serious that they cannot be dealt with satisfactorily in this way, that the investigation should be referred for independent enquiry. Action to refer such cases should be taken by the Board of Governors or the Regional Hospital Board concerned on a reference from the Hospital Management Committee. The general rule should be that an independent lawyer or other competent person from outside the hospital service should conduct the enquiry, or preside over a small committee set up for the purpose, whose membership should be independent of the authority concerned and should include a person or persons competent to advise on any professional or technical matters. The complainant and any persons who are the subject of the complaint should have an opportunity of being present throughout the hearing, and of cross-examining witnesses, and should be allowed to make their own arrangements to be legally represented if they so wish.

8. In all cases replies to complaints, including replies given after enquiries have been held, should be given with sufficient explanation and in appropriately sympathetic terms.

9. Where a complaint is received by the Minister and sent to the Board for observations (or where a complaint is received direct by a Regional Hospital Board), the procedure recommended in paragraph 7(ii) or (iii)(*a*) above should be followed if the complaint has not been previously investigated, but action under paragraph 7(iii)(*b*) should not be taken without reference to the Minister when the complaint has been referred by him.

10. It may often be useful to Boards and Committees in assessing the service being provided to the public to receive periodic reports of the number and type of written complaints, graded according to importance and subject, and they are asked to consider the desirability of introducing such a procedure where it does not already exist."

27. It should be added that a letter of 27 July 1970 to hospital authorities said:

"Patients and their relatives should not have to wait until the occasion arises before being told how to set about making a suggestion or complaint. Many hospital authorities already provide patients before admission with information

leaflets. This should become the general practice. The leaflets should include particulars of the person to whom written suggestions and complaints are to be made and suggest that patients and relatives are free to discuss problems with the nurse in charge of the ward. For out-patients the back of the appointment card can be used to provide the necessary information."

28. The hospital complaints procedure was examined by a Committee under the Chairmanship of Sir Michael Davies. The Committee's report was published in December 1973. The Department of Health and Social Security and the Welsh Office are considering it in the light of comments received from the professions or appropriate organisations and many other interested groups.

Hospital service: disciplinary procedure

29. The relevant memorandum, HM(61)112, is reproduced below. Information leading to proceedings under this circular may reach hospital authorities from any source; for example, from a patient, a practitioner's colleagues, or other hospital staff.

"*Summary*. Guidance is given on the procedure to be followed in serious disciplinary cases involving hospital doctors or dentists.

GENERAL

1. This memorandum sets out lines of procedure which, in the Minister's opinion, should govern the practice of hospital employing authorities in handling serious disciplinary charges, for example, where the outcome of disciplinary action could be the dismissal of the medical or dental officer concerned, and for cases of this kind applies the guidance contained in RHB(51)80 but replaces that contained in HM(56)98. The lines of procedure proposed are designed to ensure that justice is done and injustice avoided both to the practitioner and to the public.

2. The arrangements described below do not prejudice the right of the authority to take immediate action (eg. suspension from duty) where this is required in cases of a very serious nature.

3. There are broadly three types of case which may involve medical or dental staff:

(*a*) Cases involving personal conduct;

(*b*) Cases involving professional conduct;

(*c*) Cases involving professional competence.

It is for the authority to decide into which category the case falls.

CASES INVOLVING PERSONAL CONDUCT

4. In cases involving personal conduct, the position of a doctor or dentist is no different from that of other hospital staff. Accordingly the provisions from time to time applicable to hospital staff generally apply in such cases. These are at present those set out in the memorandum attached to RHB(51)80, of which a copy is reproduced as an appendix. These provisions are, however, currently under review.

CASES INVOLVING PROFESSIONAL CONDUCT AND PROFESSIONAL COMPETENCE

(i) *Preliminary Investigation—Establishment of prima facie case*

5. The first step when an incident occurs or a complaint is made involving the professional conduct or competence of a medical or dental officer should be for the Chairman of the Board or Hospital Management Committee (whichever is the appointing authority) to decide whether there is a prima facie case, which,

if well founded, could result in serious disciplinary action such as dismissal. Such preliminary enquiries, if any, as are necessary before this decision is reached should be in the hands of the Senior Administrative Medical Officer on behalf of a Regional Hospital Board or of the Secretary on behalf of a Board of Governors or Hospital Management Committee, whichever is the appointing authority. In appropriate cases the legal adviser or solicitor to the Board should be called in to assist. Where the matter arises from an incident for which an accident report has been made in accordance with HM(55)66, the Chairman before reaching his decision should have regard to the accident report but normally no subsequent use should be made of the report in the proceedings except in so far as it is used by the appointing authority's solicitors in preparing the case to be presented to the investigating panel (see paragraph 8 below).

6. Unless the Chairman decides forthwith that there is no prima facie case the doctor or dentist should be warned in writing immediately of the nature of the incident which has been alleged or of the complaint which has been made, and that the question of an enquiry which might lead to serious disciplinary action is under consideration. Copies of all relevant correspondence should be sent to the practitioner and he should be informed that any comments made by him will be placed before the Chairman and any investigating panel which may be appointed. The practitioner should be given reasonable time to make representations and to seek advice, if he so wishes, before any final decision is taken on whether an enquiry is necessary.

7. If on considering the allegation or the complaint made and the practitioner's comments, if any, in reply to the written warning given in accordance with paragraph 6, the Chairman decides that a prima facie case exists and that there is a dispute as to the facts, the Board or Committee should proceed to an enquiry as in paragraphs 8–15. If the Chairman decides that a prima facie case exists, but there is no substantial dispute as to the facts, any subsequent disciplinary action which the Board or Committee may take should comply with the guidance contained in the memorandum attached to RHB(51)80 (see appendix). An enquiry on the lines laid down in paragraphs 8–15 below will normally be unnecessary also where, in a matter affecting the practitioner's professional conduct or competence, the facts in question have been the subject of a criminal charge on which he has been found guilty in a court of law.

(ii) *Enquiry*

8. An investigating panel, the composition of which should differ with the type of enquiry, should be set up by the authority responsible for appointing the practitioner. No member of the panel should be associated with the hospital in question. In all cases the panel should be small, normally of three persons including a legally qualified chairman, not being either an officer of the Ministry of Health or a member or officer of the Board or Committee concerned, who will be nominated in each case which arises by the Minister from a panel appointed by the Lord Chancellor. Payment should be made by the Board to the chairman at the rate of 15 guineas for each day on which the investigating panel sits. This fee covers any preparatory work required and any time spent on preparation of reports. Travelling and subsistence expenses of both the chairman and members of the panel shall be payable in accordance with the National Health Service (Travelling Allowances, etc) (No 2) Regulations, 1961 (SI 1961 No 1792). In cases involving professional conduct, the members other than the chairman should contain an equal proportion of professional and lay persons, unless the charges relate only to relationships between a doctor or a dentist and his professional colleagues, when it would clearly be appropriate to have a panel wholly or predominantly of professional members apart from the chairman. In cases involving solely professional competence, all the other members should be professionally qualified and it will probably be appropriate that at least one of their number should be in the same specialty as the practitioner whose professional competence has been called in question, and it may sometimes be appropriate that one of them should be a practitioner from another hospital

in the same grade. Before the professional members are chosen there should be consultation with the Joint Consultants Committee. In the case of a dental officer the appointment of the professional members should be made after consultation with the Hospitals Group of the British Dental Association.

9. The terms of reference of the panel should include the nature of the incident or complaint against the practitioner who should be informed of the setting up of the panel and its terms of reference and given not less than twenty-one days' notice in order to prepare his case. He should be provided as soon as possible with copies of any correspondence or written statements made. A copy of the list of witnesses referred to in paragraph 10 and the main points on which they can give evidence should be furnished to the practitioner as long as possible before the hearing if he so requests unless for any exceptional reason the chairman of the panel gives authority for the names of witnesses not to be provided in advance of the hearing.

10. It is important that the enquiry should elicit all the relevant facts of the case. A list of witnesses should be drawn up with the main points on which they can give evidence; in the case of a Regional Hospital Board this task might with advantage be undertaken by the Legal Adviser or Solicitor to the Board, assisted by the Senior Administrative Medical Officer. Subsequently at the hearing the case should be presented by the Legal Adviser or Solicitor who should conduct an examination of the witnesses before the investigating panel. In the case of a Board of Governors or a Hospital Management Committee, these tasks would no doubt be undertaken by the Board's or Committee's Solicitor acting on the instructions of the Board which will normally be given through their Secretary.

11. The practitioner should have the right to appear personally before the investigating panel and to be represented (legally or otherwise) and to hear all the evidence presented to the panel. He should have the right to cross-examine all witnesses and to produce his own witnesses, and they and he may also be subjected to cross-examination. The question of what is to happen upon any application for adjournment in the event of the illness or unavoidable absence of the practitioner or any witness should be a matter for the Chairman to decide in accordance with the normal procedure for similar enquiries.

12. The procedure and rules as regards the admission of evidence before the investigating panel should be determined by the chairman who may, if he wishes, hold a preliminary meeting with the parties (or their representatives) for the purpose.

13. The report of the investigating panel should be divided into two parts. The first part should set out the Committee's findings on all the relevant facts of the case but contain no recommendations as to action. The second part should contain a view as to whether the practitioner is at fault and may, at the request of the authority appointing the panel, contain recommendations as to disciplinary action. In no circumstances should the investigating panel itself be given disciplinary powers.

14. The panel should send the practitioner a copy of the first part of their report and should allow a period of 14 days for the submission to them of any proposals for corrections of fact or for setting out in greater detail the facts on any particular matter which has arisen. It would be for the panel to decide whether to accept any proposed amendments and whether any further hearing was necessary to enable them thus to decide. Subject to this procedure, the facts as set out in the panel's report should be accepted as established in any subsequent consideration of the matter.

15. The Board or Committee should then receive the report of the investigating panel and decide what action to take. In the event of the investigating panel

finding that the practitioner is at fault, the substance of their views on the case and recommendations in the second part of their report should be made available to him in good time before the meeting of the Board or Committee and he should be given the opportunity to put to them any plea which he may wish to make in mitigation before they reach any conclusion as to action.

16. RIGHTS OR CERTAIN OFFICERS UNDER SECTION 16 OF THE TERMS AND CONDITIONS OF SERVICE OF HOSPITAL MEDICAL AND DENTAL STAFF.

This memorandum is without prejudice to the provisions of section 16 of the Terms and Conditions of Service of Hospital Medical and Dental Staff, relating to a consultant or senior hospital medical or dental officer who considers that his appointment is being unfairly terminated."

The memorandum, referred to in paragraph 4 of the memorandum above, is as follows:—

"1. This memorandum is concerned with procedure for dealing with disciplinary cases involving members of the staffs of Regional Hospital Boards, Boards of Governors, Hospital Management Committees, Executive Councils and other employing authorities constituted under the National Health Service Act, 1946 (apart from the machinery for the termination of the appointment of a consultant, which is set out in paragraph 16 of the Terms and Conditions of Service of Hospital Medical and Dental Staff). This subject has been considered by the General Whitley Council but up to the present no agreement has been reached and there is no generally agreed procedure for dealing with cases that arise.

2. In these circumstances the Minister thinks that some general interim guidance would be appropriate, and this memorandum sets out lines of procedure which in his opinion should govern the practice of employing authorities in this matter. The procedure suggested should, of course, be regarded as provisional, pending agreement on the Whitley Council, and is subject to review in the light of Whitley agreement. Employing authorities are accordingly asked to review their own procedures for dealing with cases of discipline and see whether it can be improved on the lines indicated in the following paragraphs.

3. The procedure is intended for cases where the more serious forms of disciplinary action are involved, and not for minor matters where for instance all that is needed is a word from the officer's immediate superior. It provides machinery for appeal to the employing authority for officers who are aggrieved, or opportunities for personal hearing, if so desired, before a final decision is reached. But it is perhaps unnecessary to say that, although satisfactory appeal machinery is very important, what is more important is a sound practice for dealing with cases at an early stage.

4. All procedure should provide for proper warning, wherever possible, of serious matters likely to involve disciplinary action, and for a right of appeal to the employing authority, or opportunity for personal hearing, before a final decision is reached. It is important to ensure, not only that justice is done and injustice avoided, but also that justice is seen to be done. The existence of a regular procedure is a valuable safeguard of this.

In reviewing their own procedure employing authorities are asked to bear these principles in mind and to follow them in making any adaptation of their own practice that may be necessary in the light of this memorandum.

5. There are broadly two types of case and different provision needs to be made for each.

(i) Employees whose employment can be terminated by an individual officer of the authority or by a committee or sub-committee of the employing authority under delegated powers;

(ii) Employees whose employment can be terminated only by a decision of the full employing authority.

6. EMPLOYEES WHOSE EMPLOYMENT CAN BE TERMINATED BY AN INDIVIDUAL OFFICER OR BY A COMMITTEE OR SUB-COMMITTEE OF THE EMPLOYING AUTHORITY UNDER DELEGATED POWERS.

An employee of a Regional Hospital Board, Hospital Management Committee, or Board of Governors, an Executive Council, the Dental Estimates Board, or a Joint Pricing Committee, who is aggrieved by disciplinary action, including dismissal, should have the right of appeal to his employing authority. The authority should from amongst its own members set up an appeals committee to hear the appeal and the employee should have the right of appearing personally before the committee, either alone, or with a representative of his professional organisation or trade union, or with a friend not appearing in a professional capacity. This appeal committee should not include any members directly involved in the circumstances leading to the disciplinary action or, where disciplinary action taken by a committee or sub-committee of the authority is the subject of appeal, members of that committee or sub-committee. The report of the committee should be submitted to the full employing authority who should thereupon reach a decision on the case.

It is important that appeals should be made and disposed of quickly, and time limits would be appropriate. It is suggested that any appeal should be lodged within three weeks of the receipt by the employee of notice of the disciplinary action, and the hearing should take place within five weeks of the receipt of the appeal.

7. EMPLOYEES WHOSE EMPLOYMENT CAN BE TERMINATED ONLY BY A DECISION OF THE FULL EMPLOYING AUTHORITY

This should be taken to include the authority's more senior grades, eg. senior professional (including nursing), administrative, or technical staff, whether or not the employing authority has devolved powers of dismissal or disciplinary action to a committee or sub-committee. (In the case of such staff the Minister considers that the authority should never have devolved power of dismissal to a particular officer, and they should review any decision they have taken as regards devolution of the power to a committee or sub-committee so as to assure themselves that such devolution is appropriate. It should in any case not be a function of a House Committee in a hospital).

If circumstances arise which might lead to disciplinary action, including dismissal, no decision in regard to the matter should be taken by the employing authority without affording the employee an opportunity of being heard. The employee should have the right of appearing personally at the hearing, either alone, or with a representative of his professional organisation or trade union, or with a friend not appearing in a professional capacity. At the hearing no member of the authority who is directly involved in the circumstances that appear to indicate the need for disciplinary action should have a part in the decision which the employing authority must thereupon make.

8. These arrangements do not prejudice the right of the employing authority to take immediate action (whether by suspension from duty or by dismissal) where this is required in cases of a very serious nature.

9. The appeal procedure which has been suggested is for appeal to the employing authority. In this paragraph, and throughout the memorandum, the term 'employing authority' is used to mean the authority whose function it is to appoint and dismiss employees of the grade in question. The procedure does not provide any *right* of appeal to any other authority beyond the employing authority. If an aggrieved employee after having exhausted the appeal procedure within his employing authority seeks to appeal to some authority beyond the immediate employing authority and applies, for instance, to the Minister or, in the case of Hospital Management Committee staffs, to the Regional Hospital Board, it is for the Minister, or the Board, at their discretion to decide what they shall do in regard to the application. Further consideration would depend upon the circumstances as they were found in the particular case: it would be for

the Minister, or the Board, to decide, and their intervention could not be claimed as a matter of right by the individual employee. In exercising discretion in such circumstances a Board should bear in mind that it is desirable that appeals be heard by persons who have not taken a direct part in the original decision against which the appeal is made."

Hospital service: "three wise men" procedure

30. The relevant memorandum, HM(60)45, is reproduced below.

"*Summary.* This memorandum suggests the setting up by Medical Staff Committees of machinery to assist in preventing harm to patients resulting from physical or mental disability, including addiction, of hospital medical or dental staff.

INTRODUCTION

1. It is possible that among hospital medical and dental staff now numbering nearly 20,000 there may occur from time to time cases of physical and mental disability during the course of their work. The Minister has considered, with the Joint Consultants Committee, precautionary measures which can be taken to protect patients from harm which might arise from incapacity on the part of hospital medical or dental staff due to physical or mental disability, including addiction. It is recognised that when members of hospital medical or dental staffs are aware of these circumstances it is their clear duty to do what they can to see that the safety and care of patients is not threatened in this way, and Boards and Committees are asked to invite Medical Staff Committees to consider this memorandum and devise specific arrangements based on the following proposals which represent the agreed views of the Minister and the Joint Consultants Committee.

SUGGESTED PROCEDURE

2. It is suggested that for each hospital or group of hospitals there should be a small Sub-committee of the Medical Staff Committee consisting of members of the senior medical staff who would receive and take appropriate action on any report of incapacity or failure or responsibility, including addiction. The precise method of achieving this should be determined by the Medical Staff Committee, but the most suitable method would probably be the election annually by the Medical Staff Committee of a Sub-committee of three or four members who should be known and readily accessible to all members of the medical staff. Local circumstances would determine whether the Sub-committee should serve a single hospital or a group or part of a group.

3. Information would normally be given orally in the first instance to the Sub-committee or whichever member of the Sub-committee is most readily available. Hospital staff, other than medical or dental staff, who have information which in their opinion should be brought to notice, should first approach the head of their department.

4. The person receiving such information should arrange discussion with other members of the Sub-committee at the earliest opportunity. If immediate action seemed to him to be necessary and other members were not available he should be prepared to take action on his own responsibility; the information received and the action taken should be reported to any other members of the Sub-committee as soon as possible.

5. The Sub-committee should make such confidential enquiries as are necessary to verify the accuracy of any report. Unless they are satisfied that the possibility of harm to patients can be excluded by the exercise of their influence with the individual concerned they should bring the circumstances to the notice of the Senior Administrative Medical Officer of the Regional Hospital Board or Secretary of the Board of Governors. It would then be the responsibility of the Senior Administrative Medical Officer or Secretary of the Board to decide if, and in what way, the information should be taken to the employing authority, and subsequently for the Board (or Committee) to decide what, if any, action should be taken.

6. Following the conviction of a consultant anaesthetist of manslaughter after he had inhaled anaesthetic gases in the course of an operation, the Minister asked the Committee on Drugs of Addiction under the Chairmanship of Sir Russell Brain to consider whether any special measures of control in the use of anaesthetics were required. In their Interim Report, which was sent to Boards and Committees with HM(60)7, the Committee advised that responsibility for dealing with such an irregularity rested in the first instance with the anaesthetist's professional colleagues and that arrangements should be made to provide for immediate action by the surgeon if an anaesthetist appeared to be incapable of carrying out his duties. Medical Staff Committees should accordingly be asked to consider, together with the general proposals made in the memorandum, arrangements for dealing immediately with this or any comparable emergency.

7. The Minister fully appreciates the difficulty and delicacy of the position of medical staff in the circumstances dealt with in this memorandum. For this reason Boards and Committees should recognise the essentially professional nature of the Sub-committee's responsibilities in these matters and accordingly, having placed trust in the Sub-committee, should rely upon it to act appropriately. If, exceptionally, any question concerning the Sub-committee's activities arises, it should be referred by the Board or Committee, before any discussion, to the Medical Staff Committee for consideration in the first instance. The Joint Consultants Committee fully agrees that a collective moral responsibility for the safety of patients rests upon the staff as a whole and that the profession should continue to co-operate in providing appropriate safeguards. Accordingly, the Medical Staff Committee has a duty to the hospital authority to do all in its power for securing that the arrangements are effective, and should carry out such duty by acting in accordance with this memorandum. The Sub-committee would be responsible to the Medical Staff Committee which appoints it, and it would be for the Medical Staff Committee in setting up the Sub-committee to determine its terms of reference and procedure within the framework outlined in paragraphs 3 to 5 above but the terms of reference should not impose on the Sub-committee a duty to report to the Medical Staff Committee.

GENERAL

8. The Minister is advised that no action for defamation need be expected to lie against members for passing on information to the hospital authority concerned, since they would be acting in pursuance of a social or moral duty to do so and the authority would have a corresponding interest to receive the information and, in consequence of this, the members of the Sub-committee would be able to claim the protection of qualified privilege. The hospital authority should, however, accept responsibility for meeting the cost of the defence of any members of the Sub-committee in any proceedings brought against them in respect of anything done or alleged to have been done in good faith in accordance with the provisions of the memorandum and should indemnify them against any damages or costs ordered to be paid in such proceedings.

9. Nothing in the procedure that is now described affects the advice contained in paragraphs 86 and 87 of the Report of the Joint Sub-committee of the Central Health Services Council on Control of Dangerous Drugs and Poisons in Hospitals, which was commended to hospital authorities in HM(58)17. If the abuse of dangerous drugs or the apparent loss of dangerous drugs is suspected the procedure in paragraphs 86 and 87 should at once apply, and the appropriate authorities consulted at an early stage.

10. It is emphasised that this machinery is intended to deal with cases of incapacity (including addiction to drugs or alcohol) in a member of the medical or dental staff which might, if not remedied, lead to harm or danger to patients. It is not intended to be used to deal with matters which are appropriate to the machinery described in RHB(51)80, HMC(51)73, BG(51)77 and HM(56)98 (at present under review) for dealing with disciplinary cases".

31. A recent circular, DS 216/74, suggesting ways in which authorities could bring the procedure regularly to the attention of staff modified the procedure in the light of the new NHS structure and suggested that it should be extended to doctors working in clinics transferred from local authorities.

Hospital service: the possibility of alerting employing authorities about unsatisfactory doctors

32. There is no formal means, comparable to the NHS Tribunal for general practitioners, whereby a comprehensive bar can be put on the practice of unsatisfactory doctors throughout the hospital service. The Department of Health and Social Security is not the employing authority for NHS medical staff and only occasionally becomes directly involved in advising authorities about individual unsatisfactory doctors seeking posts in the hospital service. The Department of Health and Social Security in 1971 issued general guidance on the procedure for checking references. Hospital authorities are periodically reminded of this guidance and of the need to conduct medical examinations on doctors newly appointed to the hospital service. In so far as there is a means of safeguarding against an unsuitable doctor receiving further employment within the health service this is normally done informally by interchange of information between Senior Administrative Medical Officers on an "in confidence" basis. The usual practice is for a Senior Administrative Medical Officer to write to his colleagues briefly on lines such as "If Dr. *X* seeks a post in your Region you may care to communicate with me before he is interviewed." As many of the doctors concerned are in the junior grades a Senior Administrative Medical Officer receiving such a letter would normally be expected to alert other employing authorities within his region. It would not be unusual for a Regional Hospital Authority to have about a dozen warning letters on current files but in many cases letters referring to the same doctor will be on the files of most if not all of the Regional Hospital Authorities. Occasionally, particularly if a doctor has newly arrived in the country or seems to be moving frequently from one employer to another, the Department of Health and Social Security will be informed. If the doctor is working in the hospital service his whereabouts can be ascertained fairly quickly either from the GMC if he is temporarily registered or from the Department's Superannuation Division. The Department of Health and Social Security then warns the employing authority. Where a doctor cannot readily be traced the Department of Health and Social Security sends out a similar "in confidence" letter to that described above to Senior Administrative Medical Officers and sometimes to Family Practitioner Committees.

III: The Health Service Commissioner

33. The re-organisation of the NHS in England and Wales on 1st April 1974 has not immediately resulted in any substantial changes in the arrangements outlined in the preceding parts of this paper, but with effect from 1st October 1973 the Health Service Commissioner has provided the public with an independent means of investigation of complaints about the NHS. NHS authorities continue to be responsible for investigating complaints made to them as part of their general management responsibilities. The Health Service Commissioner considers only those complaints made by or on behalf of patients that have already been made to the responsible health authority and have not been resolved to the complainant's satisfaction. Complainants, or those acting for them, will in all cases deal directly with the Commissioner.

34. The Commissioner is responsible for investigating actions taken by or on behalf of NHS authorities, where is is claimed that an individual person has suffered injustice or hardship through maladministration or through a failure to provide necessary care and treatment. Excluded from his jurisdiction are complaints from staff about their pay and conditions of service; the actions of general medical and dental practitioners, pharmacists, ophthalmic medical practitioners and opticians providing services under Part IV of the National Health Service Act 1946; and any action taken in the course of diagnosis, treatment or clinical care of an individual patient, which in the Commissioner's opinion, was taken solely in the exercise of clinical judgment. In cases coming within his jurisdiction, the Health Service

Commissioner will not look into complaints when the complainant has or had a right of appeal to a tribunal, or remedy by way of proceedings in a court of law, unless he is satisfied that, in the particular circumstances of the case, it is unreasonable to expect the complainant to resort or have resorted to it.

IV: INFORMATION TO THE GMC

General practitioners

35. The Secretaries of State have agreed with the British Medical Association that the GMC should be notified of the names of general practitioners in the following circumstances. First, a general practitioner who, following NHS statutory proceedings, is prevented from acting as a principal general practitioner anywhere within the NHS, is reported to the GMC. Secondly, the GMC is informed of certain cases where general practitioners are found to have failed to observe their conditions of service within the NHS. The cases reported are those involving:

(*a*) irregular certification under the National Insurance Regulations;

(*b*) irregular charging of fees to patients;

(*c*) fraud or improper claim to fees;

(*d*) canvassing or gaining of patients by unethical means;

(*e*) certain cases of overprescribing of addictive drugs;

(*f*) clinical cases of a serious nature (that is, failure to give proper treatment, failure to visit, failure to refer to hospital).

The majority of cases reported to the GMC fall within the last category. When a case is notified to the GMC by the Department of Health and Social Security it is usual to send only a copy of the service committee report, the Family Practitioner Committee's letter, and the letters conveying the Secretary of State's decision. Other documents may however be sent on request.

Hospital doctors

36. In the hospital service there is no such central co-ordinating role for the Department of Health and Social Security to play. The following guidance has been given to hospital authorities in a hospital memorandum, HM(61)37:

> "In order that the statutory bodies responsible for professional discipline may be aware of convictions in the courts leading to the dismissal or resignation of members of the professions concerned, the Minister asks that in every case the hospital authority should send a factual report of the charges and sentence to the disciplinary body. A list of the principal disciplinary bodies concerned is appended. A hospital authority is, of course, still free to report to the appropriate body the facts of any other dismissal or resignation where, in the authority's view, these facts should be made known to the body even though there has been no conviction in the courts. It is for the professional body concerned itself to decide what action, if any, to take on a report."

PART B: NOTIFICATION TO THE GMC OF DOCTORS CONVICTED OF AN OFFENCE IN A COURT OF LAW

37. This section sets out the present Home Office guidelines for notification of convictions of certain people, including doctors, to relevant bodies. It includes all groups subject to this notification because this puts the practice as regards members of the medical profession in its context.

38. The relevant Home Office circular is as follows:

> "The arrangements under which the police are asked to report, as they occur, convictions of certain groups of people and to provide certain other information

have been reviewed by a working party of officials and chief officers of police. The Secretary of State has approved the working party's recommendations and on 14 June [1973] made the following statement in Parliament:

> 'A working part of officials and chief officers of police has reviewed the circumstances in which the police are asked to report convictions of certain people in the professions and public services. The review was carried out in consultation with the organisations which receive the reports. I have approved the conclusions reached and will embody them in an early circular to the police.
>
> The effect is summarised below.
>
> The supply of police information will continue to be governed by the general principle that no information is given to anyone, however responsible, unless there are weighty considerations of public interest which justify departure from the general rule. Chief officers of police are agreed that any individual about whom a professional or public body receives a report of a conviction must be informed.
>
> In future the police will be asked to make reports of current convictions in respect of three groups of people:—
>
> (i) Doctors, dentists, nurses, persons employed in the care of children, and youth leaders—because they are in positions of trust in regard to vulnerable members of society.
>
> (ii) Civil servants, Atomic Energy Authority staff and Post Office permanent staff—in the interest of security.
>
> (iii) Barristers, magistrates, solicitors and solicitors' managing clerks—because they have a direct responsibility for the administration of the law.
>
> In respect of these groups the police will be asked to report convictions of offences, particularly those involving violence, indecency, dishonesty, drink or drugs, because they may reflect on a persons' suitability to continue in his profession or office. Minor offences, eg. road traffic offences for which there is no power to disqualify from obtaining or holding a licence, will not generally be included. But the police will be requested to report all offences by magistrates, since a series of even minor offences, eg for parking, may reflect on the fitness of a magistrate to sit in judgment on others.
>
> In addition, but only until the Department of the Environment's computer at Swansea is in operation, the police will be asked in the interests of road safety to report convictions for traffic offences by Public Service Vehicle drivers.
>
> The circumstances in which the police may be asked to give information in connection with applications for licences for other purposes have also been reviewed. Where the police are authorised by statute to provide evidence about the suitability of applicants for certain licences they must discharge their duty to assist the courts or other statutory body. The applicants in these cases know what evidence is given by the police. I consider that it would be right for the police to maintain the practice, which does not have specific statutory authority, of helping Children's Departments in considering applications for adoptive and foster parents. It is also in my view right that the background of applicants to join police forces should be checked and that the Criminal Injuries Compensation Board and the Gaming Board should be assisted by reports from the police. In all these cases the applicants will be left in no doubt that checks are being made.'

The groups referred to in the first four paragraphs of the Secretary of State's statement and the addresses to which reports should be sent are listed in detail in Schedule 1 in the annex to this letter. The groups referred to in his concluding paragraph and the bodies whom the police are asked to assist in this respect are listed in Schedule 2.

Written reports should be marked 'IN CONFIDENCE'. The bodies listed in both Schedules have undertaken to treat all reports on a strictly confidential, 'need-to-know' basis, except when the matter is dealt with in open court or at a public hearing of some other statutory body, when the usual arrangements for giving police evidence will of course apply . . .

[EXCERPT FROM SCHEDULE 1]

1. Registered medical practitioners (including those temporarily registered)	The Registrar General Medical Council 44 Hallam Street LONDON, W1N 6AE."

PART C: CONTROL OVER THE POSSESSION AND SUPPLY BY DOCTORS OF DANGEROUS OR OTHERWISE HARMFUL DRUGS

39. This section sets out briefly the present framework of control of harmful drugs by legislation as it relates to the medical profession. It should be noted that criminal convictions of drug offences and other allegations of drug abuse in recent years have been the basis for a relatively large proportion of the disciplinary cases heard by the GMC. Thus, in 1971, 12 of the 38 new cases[1] heard by the Disciplinary Committee concerned drug abuses, which had been notified to the GMC following a conviction in a court of law. In a further four cases that year, doctors were charged with having committed serious professional misconduct in respect of drug abuses.

40. The freedom of doctors to administer and prescribe certain dangerous or otherwise harmful drugs, that is "controlled" drugs, has been limited by regulations made under successive Dangerous Drugs Acts since 1920. For example, the Dangerous Drugs Regulations 1921 for the first time empowered the Home Secretary to withdraw from a doctor who had been convicted of an offence under the principal Act, or under certain Customs and Excise legislation, his authority to possess and supply controlled drugs. Controls on doctors' actions have been enacted as part of drugs legislation which has imposed general restrictions on the public's access to drugs whose abuse carries social and health problems. The number of Acts in recent years has reflected attempts to adapt the law to changing patterns of drug abuse and to the growth of the problem in the last 25 years. The current legislation is contained in the Misuse of Drugs Act 1971 which since July 1973 has replaced such previous legislation as the Drugs (Prevention of Misuse) Act 1964 and the Dangerous Drugs Act 1965 and 1967. The new Act is more than a consolidation of past legislation. In particular, it was designed to provide a less rigid framework of control which recognises that the development of drugs and the abuses which may arise therefrom are not a static matter. Thus, the 1971 Act allows a faster response to a new problem than was possible previously.

41. The first part of the Misuse of Drugs Act 1971 to become operative (in 1972) established an Advisory Council on the Misuse of Drugs. There had previously been an Advisory Committee on Drug Dependence. The Council must be consulted before regulations are made under the Act and its membership must include people with experience in such relevant professions as, for example, medicine and pharmacy, and people with good knowledge of the social problems that are related to drug abuse. The Council keeps under review actual or potential social harm from misuse of drugs, advises Ministers on appropriate controls to tackle the problem and, among a number of other functions, is concerned with education of the public and the promotion of research into the problem. Drugs which are controlled by the 1971 Act are classified in a schedule to the Act and are divided into three categories, which determine the penalties for misuse of the drugs in each category. For the first time, for the purpose of control, the Act has removed the distinction which existed in previous legislation between "narcotic" (such as heroin and opium) and "non-narcotic" drugs (such as amphetamines). The Act imposes considerable restrictions

[1]This excludes cases involving resumptions of earlier proceedings and applications for restoration to the Register.

on the production, possession and supply of controlled drugs. None the less, it is of course clear that doctors, dentists, pharmacists, veterinary practitioners and veterinary surgeons need to handle such drugs in the course of their professional duties. Details of these professions' exemption from the general law and the conditions under which their practitioners are to have access to controlled drugs are laid down in a number of regulations: the Misuse of Drugs Regulations 1973, the Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973 both of which came into operation in July 1973, and the Misuse of Drugs (Safe Custody) Regulations which becomes fully operative in April 1975. The Regulations lay down requirements on such matters as the manner of prescription, the keeping of a register of certain controlled drugs supplied by the practitioner, the notification to the Chief Medical Officer of the Home Office of persons considered or, on reasonable grounds, suspected by the practitioner of being addicted to certain drugs specified in the Regulations, and the keeping of most controlled drugs in locked receptacles.

42. The corollary to giving exemptions form the general law to doctors and certain other groups is that there are, and have been in the past, controls on practitioners who abuse their privileged position. Thus, a doctor may be served by the Secretary of State for Home Affairs with a direction prohibiting him from prescribing, administering, supplying or authorising the administration or supply of specified controlled drugs. Grounds for action includes generally conviction of any offence under the Misuse of Drugs Act or under certain provisions of the Customs and Excise Act 1952, the irresponsible prescribing of controlled drugs, failure to notify addicts, and the provision of heroin or cocaine to addicts[1]. Failure to comply with a direction is itself an offence under the 1971 Act. The power of the Secretary of State to make a direction after a conviction has been regularly used, in the great majority of cases to deal with practitioners who were obtaining controlled drugs for their personal abuse. In June 1974, 27 doctors were subject to a direction following conviction of an offence under the control of drugs legislation. The Home Office notifies the GMC of directions made by the Secretary of State following such convictions. The description in Part B of this Appendix of the arrangements governing the general reporting of convictions to the GMC by the police is also relevant in this respect.

43. Under the drugs legislation there is a Tribunal to which the Secretary of State may refer cases of practitioners whose actions he considers have given grounds for the making of a direction other than by reason of a conviction in a court of law. The Tribunal procedure is not applicable in these latter circumstances. The role and procedure of the Tribunal are mainly derived from similar provisions in previous legislation which owe their origins to the recommendations of the Rolleston Committee in 1926 but which, in fact, were never invoked. The provisions in the 1971 Act relating to irresponsible prescribing do, however, increase the prospect of the Tribunal procedure being used. This procedure has been designed to deal with the abuses by doctors of their privileged position as regards controlled drugs which primarily concern professional judgment and conduct and which it would be quite inappropriate to refer to a court of law. In such circumstances, the most acceptable procedure is for a doctor whose judgment or conduct is called in question to be brought before a Tribunal of his professional colleagues to justify his actions. The Tribunal consists of five members: a legally qualified chairman and four members of the respondent practitioner's profession. The practitioner has the right to be heard by the Tribunal and to be legally represented. Proceedings are to be in private unless the respondent requests otherwise and the Tribunal agrees to the request. After consideration of a case the tribunal may reach a number of conclusions. It may decide that there is no case to answer or that the details of the case do not merit the giving of a direction. In either case the Secretary of State informs the practitioner accordingly. Alternatively, if the Tribunal finds that the practitioner has prescribed irresponsibly and that a direction should be given, it recommends whether the direction should refer to specific or to all controlled drugs. The Secretary of State must then inform the practitioner whether he intends to make a direction, set out the details of the proposed direction

[1]Unless in the course of treatment of organic disease or injury or unless there has been a licence from the Secretary of State to do so.

and advise the respondent of his right to make representations about the case within 28 days. If the practitioner makes representations the case is referred to an advisory Body of three, consisting of a legally qualified chairman, a member of the respondent's profession who is in Government service, and a member of the respondent's profession nominated by a relevant professional organisation. After the expiry of the 28 days and, where appropriate, after consideration of the Advisory Body's guidance the Secretary of State may:

(*a*) make a direction;

(*b*) refer the case back to a Tribunal;

(*c*) order that no further action under the Act be taken.

The Home Office intends to notify the GMC of directions made under the Tribunal procedure.

44. The Tribunal procedure can be supplemented by a process which allows the Secretary of State to make a more speedy direction on a *temporary* basis than would be possible if the case were referred initially to the Tribunal. Where there are allegations of irresponsible prescribing and where the Secretary of State considers that delay might be harmful he may refer the case to a Professional Panel of three members appointed after consultation with one or more relevant professional bodies. The respondent practitioner has the right to be heard by the Panel and to be legally represented. If the Panel is reasonably satisfied that irresponsible prescribing has occurred it will report to that effect and the Secretary of State may make a temporary direction valid for six weeks but renewable for further periods of 28 days with the consent of the Tribunal. At the time of making a temporary direction the Secretary of State must also, if he has not done so already, invoke the normal procedure by referring the case to the Tribunal.

Printed in England for Her Majesty's Stationery Office by Oyez Press Limited
Dd 294703 K.5c 4/75

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ISBN 0 10 160180 8