Annual report 1974 / General Medical Council.

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1974

March 1975

THE GENERAL MEDICAL COUNCIL

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President

SIR JOHN SAMUEL RICHARDSON Bt MVO FRCP Lond

Members

Ruth Louisa Cohen CBE MA Lady Fisher of Rednal Michael Frederick Green MRCP Lond Sir John Denis Nelson Hill FRCP Lond John James Andrew Reid CB TD MD Sir John Howie Flint Brotherston MD Thomas Steele Thomas Terence Baird MB	Nominated by	Her Majesty, on the advice of Her Privy Council, or on the recommendation of the Governor of Northern Ireland
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Philip John Randle MD		University of Bristol
Walpole Sinclair Lewin MS		University of Cambridge
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Selwyn Francis Taylor FRCS Eng		Royal College of Surgeons of England
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THE WORK OF THE COUNCIL ITS MEMBERS AND ITS STAFF

by the President, Sir John Richardson, Bt, MVO, FRCP

Since the Council elected me as its President in November 1973, I have had an opportunity to study closely its work—and I have come to appreciate how difficult it is to create and maintain an effective regulating Body.

The work of a regulating Body requires many decisions to be taken each day in the various areas of its work—registration (in itself a multifarious activity, and nowadays embracing a large number of doctors from overseas), education and discipline. These decisions must be related to the circumstances of each case, but also be consistent with the Body's statutory powers, and with its policies. These policies in turn must be shaped by the facts of the situation, including the nature and limits of the Body's statutory powers—a regulating Body cannot afford the luxury of passing resolutions or adopting policies which cannot be implemented.

The performance and effectiveness of such a Body depends on a number of factors. It must be given realistic functions and relevant powers—and no doubt the Merrison Report (whose publication as I write this article is still awaited) will be largely concerned with these things. It must also have the right members and the right staff, and both must be organised in ways which enable decisions to be taken and implemented without unnecessary delay. The functions of the Council make it necessary to involve in its deliberations representatives of the three interests affected by its activities—the public who are represented by the lay members of the Council; the profession, who are primarily represented by the Council's elected members; and the educational bodies—the Universities and Colleges.

As the list of members given opposite shows, the present Council has a wealth of educational talent and experience from which it can draw. But there can be difficulty if, as is currently the case, the Council is short of members expert in certain fields such as the pre-clinical period. The elected members too are inconveniently few, especially in relation to service on the Disciplinary Committee and Penal Cases Committee. General practitioners in particular are, as a result of the choice of the electorate in 1971, currently scarce—there

are only five on the whole Council. And the three lay members must make up by the quality of their contribution for what they lack in numbers.

But even if all the right interests were fully represented, the problem does not end there. The Council is heavily dependent upon the individual abilities of its members and on their willingness to serve, sometimes at great inconvenience, on particular Committees. During the last five years there has been a much greater rate of change among the members of the Council than was formerly the case. This though it may have some advantages reduces the degree to which individual members can bring experience to the Council's work.

With 46 members the Council is too large a body itself to take decisions on all but a few of the most important matters. Most of the work has to be done by Committees or by the Council's staff. The Committees must be given delegated authority to take decisions with a clear allocation of responsibility in the different fields. The Chairmen of the Committees and the President must also have power to act quickly for many things require decisions which it would be cumbersome, unnecessary and wasteful of time to refer to a Committee.

At present the Council maintains standing Committees for education, discipline (with the preliminary sifting of cases done by the separate Penal Cases Committee), the registration of overseas doctors (which requires both a main Committee and Sub-Committees), and other aspects of registration (principally concerned with individual problems over the annual retention fee). It also has a Finance and Establishment Committee, and an Executive Committee which deals with matters not allocated to other Committees. Each Committee is elected annually by the Council. Ideally each member of the Council should serve on at least one Committee but elections by ballot rarely produce this result—some members find themselves elected to several Committees while others are left out.

But when it comes to individual cases most of the detailed work of the Council must be carried out by its staff, who give effect to the decisions of the Committees and apply them to individual cases. Even in the fields of discipline and education the work must be prepared by staff to ensure that the Committees who take the decisions are presented with the relevant evidence and information, and are aware both of the limits of their statutory powers and of any

previous decisions to which consistent policies must be related.

The staff of the Council now number over 100. The Council's work is unusual and it is important for its senior staff to be knowledgeable and experienced. The Council is singularly fortunate in its staff, led by the Registrar who has been with it for 25 years, having been appointed on January 1, 1950, to the then new post of Assistant Registrar. He has therefore had ample time to become familiar with all sides of the Council's work, which has changed and developed in new directions during this period. Mr Draper became the Registrar on April 1, 1970, on the retirement of Mr Pyke-Lees who had held the office for 19 years.

An enormous volume of correspondence comes to the Council continuously. It all requires attention. Some can be dealt with by the staff, and some after detailed examination is presented to the President or to the Chairman of one of the Committees, who are consulted on day-to-day matters ranging over the whole field of the Council's activities. The advice which the President and Chairmen of Committees receive from the officers of the Council is of a quality for which the Council and the profession should be grateful.

THE COUNCIL AND MEDICAL EDUCATION

by Sir John Brotherston, MD
Chairman, Education Committee

Survey of basic medical education

As I mentioned in the Council's last Annual Report, the Council has decided to put on record in a detailed and ordered way the different curricula and teaching and assessment methods used in our medical schools, in view of the interesting changes and rapid developments which have taken place over the past few years.

The Department of Medical Education at the University of Dundee is undertaking this survey on behalf of the Council and the "survey team" developed during July 1973 to June 1974 a series of questionnaires, with the help and advice of the medical schools at Birmingham, Bristol, Edinburgh, Glasgow, King's College, the London Hospital, and St Mary's and St Thomas's Hospitals, London, Manchester, Newcastle and Southampton, where extensive

pilot tests of the draft questionnaires were undertaken. Before the questionnaires were distributed, Deans and colleagues from each medical school in the United Kingdom and Irish Republic met the Council's Education Committee in June to give further advice on the nature of the survey and on the questionnaires, which were finally revised following this meeting.

One general questionnaire was distributed to each of the 39 medical schools during the autumn, for completion by March 1975. Depending on the arrangement of its curriculum, each school will also receive up to 35 subsidiary questionnaires which enquire in detail into the undergraduate teaching and assessment of various disciplines, for completion by November 1975. The mammoth task of collecting this information has been made easier for the survey team by the generous help and co-operation given by medical teachers, to whom the Council is much indebted.

Study of objectives in relation to basic medical education

The Council in its 1967 Recommendations included two paragraphs on "the objective in medical education" and further paragraphs on "the nature and aims of basic medical education" in which three fundamental requirements were identified. Since then the question of defining objectives in medical education has been discussed in a number of different forums and some medical schools have sought to define and establish objectives either for the whole of their curriculum or for parts of it. The questionnaires sent to medical schools for the purpose of the survey, referred to in the previous section, include questions whether objectives have been devised by the schools or by an individual Department or for a particular course. It is possible to discuss objectives in terms of scientific education, of clinical education, of education directed to producing attitudes or patterns of behaviour in the student, and of education in a doctor's social and organisational responsibilities, in terms of the need to produce with limited resources sufficient doctors of each of the various kinds needed by society and indeed in many other ways.

In view of the potential importance of this to standards of medical education the Council thought it should study the subject further. In the first instance its study is being directed to a survey of work already done. At a later stage it may be felt useful to convene a conference to provide an opportunity for medical schools to discuss together aspects of the subject. Following this the Council may

think it useful to issue a statement on objectives to supplement the guidance already given in its Recommendations on Basic Medical Education.

In embarking on this study the Council is very conscious that there are likely to prove limits to the usefulness of the definition of objectives, and has not overlooked the remark in one of the studies brought to its notice that "the blind and ceaseless generation of objectives can begin to resemble ritualistic behaviour like Lady Macbeth's handwashing . . . Statements of objectives are means . . . They ought not to become ends in themselves."

The pre-registration year

In February 1975, the Council convened a conference to discuss two matters connected with the pre-registration year – the adequacy of the number of pre-registration posts likely to be available during the next ten years in relation to the increasing number of medical students qualifying, and the synchronisation of the starting dates of pre-registration posts and of graduation dates.

A good deal of work was done in 1974 to prepare for this conference. Information was sought from medical schools, from the hospital service and from the Health Departments as to the number of medical students expected to qualify during the next ten years, the present number of pre-registration posts and increases in that number already planned. The results of these inquiries show that by 1977 the number of pre-registration posts available will have been overtaken by the rising output of the medical schools, and action needs to be initiated without delay on a national basis to secure the provision of more posts without lowering the standard of the educational experience provided. Speakers at the conference suggested various ways in which this might be achieved. The task demands the co-operation of the universities and medical schools who must satisfy themselves that new posts provide a proper educational experience, of the hospital service to provide the posts, and of the Health Departments which must fund them.

The desirability of synchronising graduation dates with the starting dates of pre-registration posts was first mooted at meetings which the Council arranged in 1972. Thereafter it was commended in the Code of Good Practice in relation to the pre-registration year which the Council issued to universities and medical schools in

1973. Synchronisation would enable the most effective use to be obtained from any given number of pre-registration posts, facilitate the establishment of regional or national matching schemes to help young doctors who have difficulty in finding acceptable posts, and help to avoid periods of unemployment between posts.

The papers prepared for the conference showed that a substantial degree of synchronisation has in fact already been achieved in Scotland and Wales and in considerable parts of England, both as regards graduation dates and as regards the starting dates of posts. A further degree will be achieved in 1979 when the University of London, which currently graduates 800 medical students a year, will bring its own graduation dates into line with those of most other universities. The conference re-affirmed the desirability of synchronisation, and it is hoped that the minority of universities and hospitals which are out of step with the general pattern—graduation in June or July and December or January and posts commencing at the beginning of August and February—will see the desirability of conforming to the general pattern.

Studies of particular topics

A conference on the teaching of psychology and sociology in basic medical education was planned during 1974 and held in February 1975. It attracted great interest. During the year the Education Committee has also considered other topics relating to particular aspects of medical education, including the instruction of medical students in family planning, the teaching of medical ethics, special arrangements for the admission of science graduates to medicine, the effect of the undergraduate curriculum on a student's choice of a subsequent career, and the teaching of rehabilitation to medical students.

THE TRAB TESTS FOR OVERSEAS DOCTORS

by R. B. Wright, DSO, OBE, ChM
Chairman, Overseas Committee

Temporary registration was introduced in 1947. The General Medical Council was given discretionary power to grant temporary registration, if it thought fit, to doctors who had qualified overseas and obtained employment in a hospital or other institution approved by the Council for the purpose. This legislation has permitted large and growing numbers of overseas doctors to benefit educationally by working in NHS hospitals. In 1949, fewer than 80 periods of temporary registration were granted; in 1953, 498; in 1963, 2,595; and in 1974, 13,177. (These figures do not indicate the number of doctors temporarily registered at any one time—a recent count of the Temporary Register showed 6,897 doctors as holding temporary registration.)

The rapid increase in numbers of overseas doctors from a great number of countries, mostly in the Middle East and Indian Sub-Continent, has thrown into relief problems of communication and deficiencies in basic medical education and attracted criticism. Criticism of the Council that its screening was insufficient to ensure reasonable linguistic and clinical competence; criticism of the profession that its representatives on appointments committees were less than thorough in determining the capabilities of candidates; criticism of the NHS that its clinical attachment scheme, which had been introduced in 1966 in an attempt to provide for overseas doctors a period of adaptation to British medical practice, placed an unfair onus on Consultant Assessors to decide whether an individual doctor could obtain employment in the NHS.

Acknowledging these criticisms, the GMC in 1973 decided that it was necessary to introduce some formal test of the linguistic and professional competence of overseas doctors seeking registration in this country. The co-operation of the non-University Licensing Bodies was sought and as a result representatives of the Examining Board in England, the Society of Apothecaries of London, and the Board of Management of the Scottish Triple Qualification met and carried out feasibility studies. In July 1974, the Temporary Regi-

stration Assessment Board was constituted. The Board co-opted advisers from the Royal Colleges of General Practitioners and of Obstetricians and Gynaecologists, and linguistic experts from the Universities of London and Lancaster, and, assisted by officers of the Council, has elaborated a four part test.

This will consist of:

1. A test of comprehension of spoken English—using tape recordings and scored by computer (duration ½ hour).
2. An MCQ paper to test factual professional knowledge covering the three disciplines—medicine, surgery and obstetrics—scored by computer (1½ hours).
3. A Modified Essay Question paper to test ability to understand written English and to write it intelligibly in a professional context (time 1 hour; marked by examiners).
4. A viva voce examination to test practical professional knowledge —e.g. in emergency situations as well as proficiency in English (20 minutes).

When the tests were first considered—in 1973—the Board and a majority of its constituent bodies took the view that a clinical examination— similar to that used in the Conjoint Examinations— was neither practicable nor suitable, but planned its tests on the assumption that they would be supplemented by a report from a consultant assessor under an improved and expanded clinical attachment scheme. Following discussion with representatives of the profession (JCC) the Council has asked the Board as a matter of urgency to explore further the introduction of a clinical examination.

The standard of the tests will be related to the standard reached by a British qualified doctor on full registration—that is to work at SHO level. It is proposed in future to publish figures showing the results of the Board's tests and to institute a monitoring survey of their efficiency.

For those seeking temporary registration for the first time after June 1975, the Council has determined that an adequate performance in the tests will be mandatory—except for acceptably sponsored doctors coming to this country under special arrangements to hold particular academic or other institutional training posts. If any doctor so exempted subsequently wishes to obtain

temporary registration for other appointments he will be required to pass the tests.

The Board is to hold its first test in Edinburgh on June 23, 1975, and thereafter to conduct ten tests yearly divided between three centres—Edinburgh, Glasgow and London with a planned capacity of about 2,500 per year.

Present legislation precludes the extension of the tests to any overseas doctor who is entitled to provisional or full registration under reciprocal arrangements. The Council has, however, over the past two years, been conducting a comprehensive survey of the overseas qualifications recognised for this purpose, and has withdrawn recognition from some. The GMC has also made recommendations to the Merrison Committee designed to limit recognition for full registration of qualifications obtained overseas to those medical schools of whose standards the Council is able to satisfy itself, and to remain satisfied.

PROFESSIONAL DISCIPLINE

Complaints against doctors

by Sir Denis Hill, FRCP
Chairman, Penal Cases Committee

Each year the Council receives many letters about the conduct of doctors from members of the public, from other doctors or from official bodies such as government departments. Many complaints from the public are trivial or come from obviously deluded persons or relate to matters such as diagnosis or treatment over which the Council has no jurisdiction. In addition convictions of doctors in the criminal courts, with the exception of traffic offences or minor matters, are reported to the Council by the police. All convictions are referred automatically to the Penal Cases Committee which must decide whether the question of the doctor's fitness to practise is raised. A few convictions for very serious offences are notified each year, and the doctor may be in prison or, if mentally ill, in hospital. The great majority however are related to the abuse of alcohol, often while driving, which, if repeated, must raise the question of the doctor's fitness to practise. There may be associated evidence in the

police or other reports to suggest that this is so. The Penal Cases Committee has the discretion to adjourn to their next meeting any matter and in particular in cases of drug or alcohol abuse to make further enquiries whether treatment has been undertaken.

The President, or the Council member appointed by him to act in the preliminary stages of discipline, is therefore more concerned with cases of alleged misconduct than with cases where a conviction has occurred. This does not in general involve him in making difficult judgments on nice points of medical ethics. Rather he must decide whether the doctor's alleged behaviour does raise the question of serious professional misconduct and, if so, whether the facts alleged are capable of proof. What does the evidence amount to, and is any further evidence likely to be available? How long ago did what is alleged happen? The Council has always been reluctant to consider matters that are said to have occurred more than a few years before, if only because of the difficulty of proving them. In making decisions he is helped by precedent and by the meaning of serious professional misconduct as defined in well-known judgments in the Courts of Appeal, and he may require that further enquiries be made by the Solicitors to the Council. Before a complaint by a member of the public can be placed before the Penal Cases Committee it must be set out in the form of Statutory Declarations. Occasionally the help of the Council's Solicitor is offered to the complainant for this. If a decision is taken that there is a *prime facie* case to answer, a letter setting out the allegations is sent to the doctor who is asked for his explanation. His reply, usually prepared with him by solicitors or by his Defence Society, may then be placed, together with the complainant's allegations, before the Penal Cases Committee. But the doctor's explanation may prove sufficient, and the matter can then be concluded.

In 1974 the Penal Cases Committee considered twenty cases of alleged misconduct and seventy-four cases of conviction. The Committee must consider the same factors – the seriousness of what is alleged, the quality of the evidence (now helped by the Legal Assessor), and how the matters, if true, affect the doctor's fitness to practise and the reputation of the profession. Last year sixteen cases of alleged misconduct and eleven cases of conviction were referred to the Disciplinary Committee. The decision to refer to the Disciplinary Committee, with its attendant publicity and potential consequences, involves the doctor in a degree of anxiety and distress which no one

would wish for a colleague. This distress is no doubt compounded by the fact that, in a considerable proportion of all cases which appear before the Disciplinary Committee, the matters considered have already been dealt with elsewhere – either in the criminal courts or through the complaints machinery of the National Health Service.

The Council has for a long time been aware of the many mentally disordered doctors, including those dependent upon alcohol or drugs, who come to their notice often through repeated convictions or complaints raised against them. There has always been a reluctance on the part of successive Disciplinary Committees to use 'disciplinary' methods of control, when clinical and therapeutic ones are obviously called for, but the Medical Acts at present provide no other means by which to protect the public, or indeed of helping the sick doctor. Proposals for dealing with these cases outside the disciplinary procedures, enabling the registration of mentally ill doctors who are unfit to practise to be controlled, were published by the Council in 1972 and have been considered by the Merrison Committee. If accepted, they will require legislation. Meanwhile the Penal Cases Committee, confronted with a doctor's deteriorating standards of practice, has to consider whether a private warning or an adjournment with a requirement of confidential reports at the end of it may be effective, or whether to refer to the Disciplinary Committee.

Among the most difficult problems with which the Council has to deal are those concerned with advertising. Here most of the complaints against doctors are made by doctors. Questions are raised about doctors who broadcast or who appear on television or who write articles or books for the lay public. More complex are the issues raised by the relationships between doctors and organisations which advertise diagnostic or therapeutic services either to the profession or to the lay public. Considerable publicity and criticism have recently been aroused by the activities of some doctors in the abortion field. In some cases the question arises how far the Council should embark upon expensive investigations when only the flimsiest evidence is immediately available. In others the conduct of a doctor may appear distasteful, or even unethical, but nevertheless to fall short of serious professional misconduct. If so, the Council cannot deal with it as disciplinary matter.

Summary of cases considered during 1974

The Penal Cases Committee held three meetings and the Disciplinary Committee sat on 24 days during 1974. The Disciplinary Committee considered 22 new cases and 17 other cases in which judgment or the finding had been previously postponed or the doctor's registration suspended. The Committee also considered one case of fraudulent registration. Nine cases involved more than one hearing during the year. Restoration to the Register following disciplinary erasure was granted to four applicants.

The nature of the offences, or alleged misconduct, which gave rise to the cases which were considered by the Penal Cases Committee and the Disciplinary Committee during the year is indicated in the table opposite. Some cases involved more than one kind of offence or alleged misconduct, and are shown in more than one column.

Of the 39 cases of professional discipline which were considered by the Disciplinary Committee, 24 arose, wholly or in part, out of previous proceedings in the criminal courts. Seven arose out of previous proceedings under the National Health Service regulations, and two (each of which alleged improper association with a patient) were brought by private complainants. Eight cases originated from other sources, including two cases which also arose in part from criminal court proceedings.

The Disciplinary Committee ordered erasure in three cases and suspension in eight, three being extensions of suspension previously ordered. In three of these cases the Committee also ordered immediate suspension; two of these cases involved prescribing otherwise than in the course of *bona fide* treatment, and one involved abuse of alcohol and drugs.

In 66 of the cases considered by the Penal Cases Committee but not referred to the Disciplinary Committee, and in 22 further cases, warning letters were sent to practitioners following proceedings in the criminal courts or elsewhere in which findings had been made reflecting on the professional conduct of the doctor.

The Council received during the year a total of 847 complaints or letters about professional conduct from members of the public or of the profession.

Nature of Alleged Misconduct, or Offence of which Convicted	*Cases considered by the Penal Cases Committee but not referred to the Disciplinary Committee*		*Cases considered by the Disciplinary Committee*	
	Convictions	*Alleged Professional Misconduct*	*Convictions*	*Alleged Professional Misconduct*
1 Disregard of personal responsibilities to patients (for example, by failure to visit)	0	5	0	4
2 Abuse of alcohol	38	1	4	0
3 Personal abuse of drugs by the doctor	5	2	13	1
4 Non bona fide or improper prescribing of drugs of addiction for others	1	1	3	4
5 Illegal abortion	0	0	1	0
6 Abuse of professional position to further an improper association or commit adultery	0	5	0	2
7 Breach of professional confidence	0	1	0	1
8 Dishonesty	13	0	2	5
9 Violence	5	1	0	0
10 Indecency	4	0	1	1
11 Advertising or canvassing	0	3	0	2
12 False certification	2	1	0	0
13 False claim to possession of qualification	0	0	0	2
14 Other charges	7	2	0	0

Notes

2 Convictions in this category were mainly of driving while drunk.

3 Convictions in this category were mainly of offences against drugs legislation or of obtaining drugs by deception.

Delegation of medical duties to non-medical persons

During 1974 the Council revised the section of the blue pamphlet on Professional Discipline which warns doctors against the improper delegation of medical duties to persons who are not registered medical practitioners. The section now reads as follows:

> **(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 practitioner.

Relations with non-medical acupuncturists or skin technicians

During 1974 the Council was asked to advise on the position of doctors who might wish to refer patients to non-medical acupuncturists. Advice was given that it was not for the Council to attempt to dictate to doctors whether or not they should seek to have patients treated by acupuncture. If a doctor decides that it would or might be beneficial to one of his patients to be treated by acupuncture, the doctor may either arrange for the process to be carried out by a registered medical practitioner who has acquired this technique or he may refer the patient to a non-medical acupuncturist. If the doctor adopts the latter course he would need (*a*) to retain ultimate responsibility for the management for the patient and (*b*) to satisfy himself that the procedure is within the capacity of the person to whom the patient is referred. On the last point, the Council cannot pronounce on the adequacy of any particular course of training or qualification for persons who are not registered medical practitioners. On such matters the individual doctor must make his own inquiries and seek his own advice.

The Council was also asked for advice on the position of a doctor

who wished to refer a patient to skin technicians for testing or treatment. Once again advice was given that the referral of patients to appropriately qualified technicians could not give occasion for reasonable complaint provided that the doctor concerned retained ultimate responsibility for the management of the patient.

Advice on professional conduct: discussions on advertising

As recorded in the last Annual Report the Council concluded in 1973 that in future it would be appropriate for any central regulating body of the medical profession to take a more active role in relation to the issue of guidance on questions of professional conduct than the Council had assumed in the past. During 1974 a series of discussions on this subject took place between the Council on the one hand and representatives of the British Medical Association and of the three Medical Defence Societies on the other. These discussions were extremely cordial. All concerned agreed that it would be useful if the Council were able to issue supplementary guidance in certain specific areas of professional conduct, although the giving of advice to individual doctors was still seen primarily as a function for the Societies and the Association.

Discussions between the Bodies during 1974 explored principally questions of advertising arising in certain areas—questions arising from relationships between doctors and organisations providing clinical, diagnostic or medical advisory services and questions of advertising arising from articles or books, broadcasting or television appearances by doctors. The discussions, however, also illustrated the extreme complexity of these matters and often brought to light problems arising in the considerable area which may exist between high standards of professional conduct on the one hand and on the other conduct so undesirable that it could be regarded as amounting to serious professional misconduct.

These discussions are still continuing and it is hoped that during 1975 some positive results will emerge.

REFLECTIONS ON A COMPUTERED REGISTER

by J. Pedley
Assistant Registrar

Computers are pretty unappealing to most laymen. There is an Olympian inaccessibility about them. The mysteries are preserved by a hieratical band of initiates who use a peculiarly daunting form of jargon. They seem bent on obfuscation. You have to have been on a course—or at least to have read a book—to get the drift of any but the simplest sort of conversation with them. If you are accorded the special privilege of access to the divinity Itself—"you might like to see what actually happens . . ."—the sense of frustrated bafflement deepens. The *deus in machina* stutters and clicks, a complete enigma. Yet this Thing contains—indeed, knows—all the facts comprehended in the Register. Wistful recollections return of a Register bound in leather and "kept" by an amiable middle-aged lady with a pleasing bold hand and a fine flourish of the red ink pen. You knew where you were with her.

These reflections recur but the wistfulness soon subsides. The way things are now, we could not possibly do without the services of our computer bureau. The belief incidentally which from time to time is still expressed that the Council owns its own computer is a myth. It merely buys the services of the staff and computers maintained by a bureau. All it actually owns are five machines which are each a sort of hugely elaborate typewriter. These machines convert information regarding all alterations to the Register into a form capable of ingestion by the computer. At the same time they produce among other things the cards (containing each person's registered particulars in their most recent form) for the index which now constitutes the Register proper. The leather-bound tome has gone, but the Register retains a tangible and accessible form. The calligraphic lady has departed, but at least one does not have to run the gamut of the experts before ascertaining a doctor's registered particulars.

Why then the computer? Partly because of its application to the collection of retention fees. Doctors seem aware of the computer's implication in this, and sometimes utter an almost personal vilifica-

tion. "Tell your damned computer..." roared someone recently on a returned remittance form which had credited him with a slightly incorrect address. But in this sphere the computer is the veriest boon and blessing—indeed, it is indispensable. Every other Friday it is fed with information regarding the alterations to the Register which have taken place during the preceding fortnight, and every other Monday it produces lists of doctors from whom payments are shortly due, with all the attendant listings, stationery, and certificates required for the purpose of securing those payments. Its speed and versatility is astonishing: it can as readily cater for 6,000 prospective payers at one go as 1,500. The attempt to operate such a system by conventional clerical methods would be quite impossible.

The other main function of the computer is its use in connection with the printing of the Medical Register and the lists published each fortnight as supplements to it. Again, the layman feels foreboding. Printing to him is a pretty elemental form of industrial activity, involving printer's ink and tiers of heavy metal type, portions of which can actually be altered visibly. For the Medical Register a bloc of "standing type" weighing ten tons used in former times to be preserved from year to year, carrying forward from one Medical Register to the next the mass of unchanged entries. Come the turn of the year, and the curiously satisfying chore of checking the insertions, removals and alterations to the previous year's record. Now that technology has dreamt up computer type-setting, however, the computer can do all the amending, adding and removing in a trice, can sort from the names of persons on its record those which should appear in the current Medical Register and convert them into pages of film for reproduction of it. In theory the operation is straightforward and foolproof. Theory is not always borne out in fact, but savings in time and cost are considerable.

We are partly reconciled. Some of us have been on courses. We have even become reconciled to the fundamental claim that the computer can of itself do no wrong but errs only in carrying out insufficient or incorrect instructions. But to be able fully to appreciate the wondrous works of the computer you have to think like one. Few can: I don't.

FINANCE

The Council's income and expenditure for 1974 may be summarised as follows:

Income		*Expenditure*	
Annual retention fees	£377,290	Education	£27,091
Fees paid on provisional or full registration:		Discipline	£60,922
British and Irish doctors	£67,510	Registration of British and Irish doctors; Maintenance of Register	£61,132
Overseas doctors	£69,305		
Temporary registration of overseas doctors	£94,015	Registration of overseas doctors	£87,981
Sales of the Medical Register and Fortnightly Lists	£27,067	Collection of annual retention fees	£70,281
Other income	£36,546	Printing of Medical Register and Fortnightly Lists	£25,453
		General administration and establishment	£187,116
Total income for year	£671,733	Total expenditure for year	£519,976

Most of the foregoing items are self-explanatory. Expenditure under the heading "General administration and establishment" represents all expenditure which cannot realistically be apportioned among the various activities shown in the summary including such matters as meetings of the Council, costs of staff employed on common services and expenditure on premises.

During 1974 the total expenditure of the Council increased by £128,167 as compared with 1973, whereas total income rose by only £9,154 and receipts from the annual retention fee fell by £8,030. Most of the increased expenditure resulted from inflation. Nearly three-fifths of the Council's total expenditure is on staff salaries and superannuation, and both of these are directly affected by inflationary trends.

Part of the surplus of income over expenditure was appropriated to the Superannuation Fund in respect of a renewed liability for past service (superannuation benefits are linked to final salaries: as these rise with inflation so a new liability arises). The remainder was appropriated to the General Reserve. But by the end of the year the total value of the Council's investments was still little more than half of its annual expenditure.

While therefore the Council's financial position for 1974 was satisfactory the trend shown is of expenditure rising from inflation with stationary income; and if inflation continues, it will become necessary to increase the Council's income.

Copies of the audited accounts may be obtained from the Registrar on request.

PERSONALIA

The Council lost five members through retirement or resignation during 1974.

Professor Malcolm Millar, CBE, MD, represented the University of Aberdeen where he was both Professor of Mental Health and Dean of the Faculty of Medicine from December 14, 1967, until May 2, 1974. While on the Council he served on the Special Committee on the Registration of Doctors affected by Mental Disorder and on the Disciplinary Committee.

Mr Alan Parks, FRCS Eng, who is Consultant Surgeon at the London Hospital and St Mark's Hospital, London, represented the Royal College of Surgeons of England from August 22, 1972, until August 21, 1974, when he resigned following his appointment as Chairman of the Joint Consultants Committee.

Sir Brynmor Jones, ScD, who was formerly Vice-Chancellor of the University of Hull, was nominated by the Crown as a lay member of the Council from September 29, 1964, until September 28, 1974. During this time he served on the Disciplinary, Executive and Education Committees. He always showed the greatest interest in all the activities of the Council and chaired the Working Party on the Composition of the Council which in 1971 produced the "Brynmor Jones Report".

Professor Robert Kellar, CBE, FRCS Edin, who was Professor of Obstetrics and Gynaecology at the University of Edinburgh, represented that University on the Council from February 1, 1964, until September 30, 1974. During this time he served on the Disciplinary, Education, Public Health, Overseas and Registration Committees. He also visited, on behalf of the Council, the Universities of New South Wales and Monash, the Medical School at Peradeniya, Ceylon, and the three Medical Institutes in Burma in 1966. In 1969 he visited the University of Malaya and in 1971 the University of Tasmania.

Sir John Peel, KCVO, FRCOG, represented the Royal College of Obstetricians and Gynaecologists on the Council from January 31, 1970, until January 30, 1975, and served on the Disciplinary, Executive, Education, Overseas, Public Health and Finance and Establishment Committees. He was elected a Treasurer of the Council in 1972, and gave of his wisdom in many fields.

To replace these members Mr Selwyn Taylor, FRCS Eng, Surgeon at the Hammersmith Hospital and Dean of the Royal Postgraduate Medical School, has been appointed by the Royal College of Surgeons of England. Lady Fisher of Rednal has been nominated by the Crown as one of the lay members of the Council. Lady Fisher was formerly a Labour Member of Parliament for the Ladywood Division and a member of the Birmingham City Council. Professor A. S. Duncan, DSC, FRCOG, Executive Dean of the Faculty of Medicine and Professor of Medical Education at the University of Edinburgh, has been appointed by that University. Professor S. C. Frazer, FRC Path, Dean at Aberdeen and Professor of Chemical Pathology, represents the University of Aberdeen. Mr Donald B. Fraser, FRCOG, who is Gynaecological and Obstetric Surgeon at St Bartholomew's Hospital, London, has been appointed to represent the Royal College of Obstetricians and Gynaecologists. In addition Sir Ronald Gibson, CBE, FRCGP, a former Chairman of the Council of the British Medical Association and a general practitioner, was elected in September 1974 to represent the registered medical practitioners in England and Wales, and fill the casual vacancy arising from the resignation of Dr Pigott mentioned in the last Report.

CHANGED YOUR ADDRESS?

This Report is being sent to practitioners at the addresses shown in their entries in the Register on April 18, 1975. Any change of address notified on or after that date will have been included in the Register if you have received a letter acknowledging the notification and confirming the newly-registered address. Please keep the Registrar informed of all changes of address and check that new addresses have been correctly registered. If you receive no confirmation, write or telephone to the Council's office at 44 Hallam Street, London, W1N 6AE: telephone 01–580 7642.

PUBLICATIONS OF THE COUNCIL

The following publications may be obtained from the Registrar:

Medical Register 1975	£13
Fortnightly Supplementary Lists	
ie Lists of names added to Register	£21
Lists of names removed	£16
Lists of changes of address	£26
Minutes of the Council, annual volumes	£3
List of Approved Hospitals and Recognised House Officer Posts: Seventh Edition (in preparation)	£2
Recommendations as to Basic Medical Education (1967)	*
Code of Good Practice for Universities and Medical Schools in relation to the Pre-registration Year (1973)	*
Professional Discipline (the "Blue Pamphlet")	*
Constitution and Functions of the Council	*
Annual accounts	*

**No charge for single copies*

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The Council's seal or emblem shown
on the cover was designed and adopted in 1862.
The Council's records contain no details about the intention
of the designer or the symbolism.
The figure is Hygeia.

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1974

March 1975