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GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1976

March 1977

THE GENERAL MEDICAL COUNCIL

March 1977

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THE COUNCIL

by Sir John Richardson, Bart, MVO, MD, FRCP Lond
President of the General Medical Council

In our last Annual Report I wrote at some length about "the Council and the Merrison Report" and concluded by saying that "the Council has reacted very positively to the Merrison recommendations. It has taken the initiative in promoting discussions with other professional bodies to ascertain where there is agreement, but the completion of the process, including the accomplishment of important changes on medical education and registration, depends upon legislation for which the Government must be responsible".

I wrote those words in March 1976. At that time eleven months had elapsed since the publication of the Merrison Report and we had every reason to hope that legislation to implement it would very soon be introduced. Since then a year has passed but the legislation has not been enacted which is necessary in order to accomplish the main changes recommended in the Merrison Report. These include the integration of all the stages of medical education – undergraduate, the pre-registration year, and vocational training leading to registration in the doctor's chosen specialty, whether this be general practice or one of the branches of hospital medicine; further changes in the arrangements for the registration of overseas doctors which have been generally agreed to be desirable; provision for dealing with the problem of the sick doctor and a change in the composition of the Council to enable it adequately to discharge these new functions.

None of these changes can be accomplished without legislation. The Council has therefore repeatedly urged upon the Government the need for early action on this matter.

The absence of legislation is very disappointing. In the meantime the ordinary work of the Council must continue. The following pages of this report show that in 1976 the Council has not been idle. Separate articles describe its continuing activity in medical education, in the administration of professional discipline, in the registration of overseas doctors, and in devising arrangements to implement the Medical Directives of the EEC.

In addition to the activities mentioned above I should like to

mention two other fields which have occupied the Council's time during 1976. One is the preparation of further guidance on professional conduct. As I mentioned in our Report for 1975 the Council had during that year added new sections to its blue pamphlet on *Professional Conduct and Discipline* giving guidance on various questions of advertising – specifically questions arising from relationships between doctors and organisations providing clinical, diagnostic or medical advisory services and questions arising from articles or books, and broadcasting or television appearances by doctors. During 1976 the Council continued its efforts to elaborate and up-date the guidance given in the blue pamphlet on sexual relationships between doctors and patients. For this purpose a Committee of the Council had repeated discussions and correspondence both with the British Medical Association and with the Medical Defence Societies. These discussions proved very useful. They also illustrated the difficulty of achieving a consensus of view in this area on the formulation of useful guidance to practising doctors but I am glad to be able to report that a large measure of agreement was eventually reached. The pursuit of this objective was eventually found to make desirable a substantial revision of the entire pamphlet, and the fruit of all this work by a Special Committee will be presented to the Council in May. If the Council then agrees a new edition of the blue pamphlet will be published and distributed to every doctor later in 1977.

During 1976 the Council received, in common with many other medical bodies, an invitation to submit evidence to the Royal Commission on the National Health Service. Many of the problems being examined by the Royal Commission fall outside the statutory responsibilities of the Council. Nevertheless the Council's responsibilities for the undergraduate training of doctors, for the registration of doctors who have qualified overseas and for professional conduct and discipline made it desirable for the Council to offer evidence on matters arising from these responsibilities. The evidence eventually presented by the Council dealt with, among other matters, the boundaries of the responsibilities between medical and other professions and issues of professional and clinical freedom. On the former topic the Council expressed the opinion that the question whether each and every function which traditionally has been performed by a doctor must continue to be confined to doctors needs to be systematically and regularly examined. Accordingly the Royal Commission should explore whether provision is desirable for more regular and formal monitoring of changes in the boundaries of

responsibilities between the medical and other professions in order to ensure that changes which have become desirable are not unnecessarily delayed. Any changes in practice would of course require changes in the training given to members of the different professions and cross representation between the professions on the bodies responsible for regulating professional training could be most desirable and necessary.

The evidence of the Council emphasised that doctors placed great value upon clinical freedom and regard it fundamental that their judgment of the needs of each patient should not be subject to external interference or direction. The Council nevertheless recognised that some constraints will always be imposed on clinical freedom by the availability of resources. In order to ensure the best use of resources and to avoid frustration, doctors must be educated in the use of resources and in their economic implications. They must also play their part in the allocation of resources at all levels including local levels.

The Council in its evidence also referred to the absence of job satisfaction felt by doctors working in the Health Service as being to some extent responsible not only for unacceptable levels of medical emigration but as having also affected the attitude of many doctors who remain in this country. The Council felt that the absence of job satisfaction has many causes. Some of these are linked to the absence of a realistic career structure in the hospital service. Accordingly the Council expressed the hope that the Royal Commission would study these problems which in its opinion are central to the terms of reference of the Royal Commission – namely to consider both in the interests of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the Service.

THE COUNCIL AND MEDICAL EDUCATION

by John N. Walton, TD, MD, DSc, FRCP Lond
Chairman, Education Committee

One of the Education Committee's most important functions relates to the guidance it gives to Medical Schools on the content of basic medical education. In 1976 some five established Medical Schools found it helpful to consult the Committee about proposed changes in their curricula.

The procedures in respect of new Schools have a similar purpose but are necessarily more wide-ranging.

The Council and new Medical Schools

Three new Medical Schools have been established in Great Britain in recent years, the first to have been opened for many years. The University of Nottingham admitted its first undergraduate medical students in 1970, the University of Southampton a year later and the University of Leicester in 1975. The first medical graduates of the Universities of Nottingham and Southampton are now registered and practising, and the first students from Leicester are expected to graduate in 1980. The Council, through its Education Committee, has had, and in the case of Leicester still has, an important role to play in guiding the new Schools towards the achievement of medical degrees which confer the right to registration. A brief outline of the procedures followed may be of interest.

The procedures are new. Previously when a new University first began to grant medical degrees it was necessary to secure by legislation that the examinations which it held for the purpose of granting these degrees should become qualifying examinations for the purpose of registration under the Medical Acts. The Medical Act of 1969 changed this procedure, giving authority to the Council, if it felt that the standard of proficiency required from candidates at examinations held by a new University was sufficient in terms of the Medical Act of 1956, to make representations to the Privy Council that such examinations should become qualifying examinations for the purposes of Part II of the Act. An Order made by Her Majesty in Council might then give effect to the representations.

In order to be satisfied of the standard of the examinations held by

each University, and of the nature and content of the instruction given in its Medical School, the Council has followed similar procedures in relation to Nottingham and Southampton and is doing so again with respect to Leicester. Each School has been asked to provide the Education Committee with information about the undergraduate curriculum as it has evolved; discussions have then been held between representatives of the Education Committee and of the Medical School, and then the Universities have invited the Council to visit and inspect the teaching programme and examinations at such times as the Council considered appropriate. Visitors and inspectors (who may not be members of the Council) are then appointed to act on its behalf; usually one visitor is concerned particularly with the basic medical sciences, one with behavioural science and two with clinical disciplines. Normally each team visits each School at least twice in order to study different stages of the curriculum and the relevant examinations. The reports of the visitors are then presented by them and discussed with the Education Committee before being returned to the individual Medical School for comment; finally they are sent to the Privy Council together with any observations made by the University and by the Council on the advice of its Education Committee. The reports on Nottingham and Southampton were very favourable and the Council was pleased to endorse the conclusion of the visitors and inspectors that the courses of instruction and examinations held should be deemed "sufficient" in terms of the Medical Acts.

Survey of Basic Medical Education

I gave in last year's Report an account of the progress made on the Council's Survey of Basic Medical Education, a three-year project undertaken in order to put on record the curricular changes which have been introduced or are being planned, and the difficulties and constraints which are facing Medical Schools today in the pursuit of their objectives, following the publication in 1967 of the Council's Recommendations as to Basic Medical Education and in 1968 of the Todd Report.

The Survey was completed in June 1976. A data bank, containing the mass of information collected from comprehensive questionnaires completed by each Medical School, has been established and information from it will be made available on request to persons or organisations who are interested in basic medical education, although detailed information about a particular School will not be released without that School's consent.

The report on the findings of the survey is now being printed. The Council is most grateful to the Nuffield Provincial Hospitals Trust, which has undertaken to publish the report on the Council's behalf and to arrange distribution and sales. It is hoped that the printed copies will be available in the autumn of 1977. The report has three main sections, one giving a detailed analysis of medical education as it existed in the British and Irish Medical Schools in late 1975 and early 1976; the second section includes "profiles" of the individual Schools and in the third section the report analyses the content and methods of teaching of individual subjects, disciplines and specialties. I believe that this report will provide an invaluable analysis of contemporary medical education in Great Britain and Ireland and will be of lasting value.

Survey of the Pre-Registration Year

During the year the Committee considered a number of matters relating to the pre-registration year, including the important problem of providing sufficient posts for the increasing output of medical graduates, and possible future action by the Council on the recommendations in the Merrison Report on graduate clinical training. The Committee also decided to institute a survey of developments since the publication of the Council's Code of Good Practice in November 1973, to ascertain the extent to which Schools have been able to implement the recommendations of the Code. This survey is on a considerably smaller scale than the Survey of Basic Medical Education referred to in the previous paragraph. Its results will be considered by the Committee in May 1977.

Conference on the Objectives of Basic Medical Education in February 1977

The last Annual Report referred to a report on Objectives in relation to Basic Medical Education which was presented to the Education Committee and Council in 1975, and considered also at a meeting with Deans in March 1976. The report was discussed further at a conference held on February 24, 1977. The subjects of the two sessions of the conference were "What sort of doctor: the definition and attainment of objectives" and "The objects and methods of examination and assessment: the changing role of the external examiner". A report of the conference will be published later in 1977.

Conclusions

The last year has been one of continuing activity and change in the field of medical education. Several new and important topics, not least some of those related to the work of the Advisory Committee on Medical Education of the EEC which has the responsibility of formulating advice on medical education in the member countries, have emerged and will require the attention of the Education Committee in the coming year. The publication of the results of the Council's Survey of Basic Medical Education will represent a significant landmark and I am grateful to my predecessor, Sir John Brotherston, who initiated the Survey, to the members of the Committee, to the Survey Team in the Department of Medical Education of the University of Dundee, and to the members of the Council's staff who have contributed to this important achievement.

FREE MOVEMENT OF DOCTORS WITHIN THE EUROPEAN ECONOMIC COMMUNITY

by M. R. Draper
Registrar

December 1976 marked, or should have marked, the beginning of an interesting new chapter in the Council's history, involving new functions connected with the free movement of doctors among the nine States of the European Economic Community.

The concept of free movement was embodied in the Treaty of Rome negotiated in 1957 between the original six countries of the Community. The United Kingdom did not join the EEC until 1972, and its continued membership of the EEC remained in doubt until after the referendum held in June 1975.

The Treaty of Rome (which later became known as the EEC Treaty) in itself provided only in bare outline for freedom of movement. This was based on the right of a national of any Member State to work in another Member State either on a permanent basis ("establishment") or temporarily ("prestation"). The practical arrangements necessary to make these two rights available for doctors were the subject of prolonged negotiations between the governments of the original six countries. Eventually "Directives" were adopted by the Council of Ministers of the European Community on June 16, 1975. Although these were not issued until after the date on which the United Kingdom had joined the Community, the terms of the Directives had largely been agreed much earlier and substantially reflect the organisation and structure of medical practice in the Continental States.

Under the EEC Treaty the Directives must be given effect in each country, and if necessary each country's own laws must be altered to comply with them. This, because of the philosophy and language in which the Directives are formulated, has posed problems for the United Kingdom. The Directives were supposed to be given effect in each Member State by December 19, 1976. The Government therefore had 18 months from June 1975 to December 1976 to amend the Medical Acts of the United Kingdom in order to harmonise them with the requirements of the Directives. The European Communities Act 1972 of the United Kingdom gave power to Her Majesty by Order in Council to amend United Kingdom legislation and a draft Order in Council was prepared for this purpose.

In order to give effect to the Directives it was necessary to empower the General Medical Council to grant full registration to doctors who had qualified in and were nationals of a Member State of the EEC. It was also necessary to designate certain bodies in the United Kingdom as competent to provide British qualified doctors with evidence of their qualifications – both basic (e.g., MB BS) and specialist – and of their registration, good character, physical and mental health and any other matters which may be required to enable them to establish themselves or to render services in another State. Finally, it was necessary to make arrangements for the control and discipline (so far as permitted by the Directives) of doctors from other Member States who establish themselves or provide services temporarily in the United Kingdom.

Unfortunately the Government did not make the contemplated Order in Council during 1976, and at the time (February 1977) when this report was written the Order had still not been made. This left the Council in the unenviable position of having no authority under domestic legislation to give effect to the obligation imposed by the EEC Directives to grant full registration to doctors from the Continental Member States. Lack of similar statutory power was of less consequence to British doctors seeking to emigrate since the Council was formally designated by the Government as competent to issue to them the documents which they might need for practice in the EEC. These included Certificates of Specialist Training or Certificates of Equivalence in any of the 36 specialties which are recognised for this purpose (General Practice at present is not).

In many of the Continental Member States registration as a specialist confers certain advantages. The standard of the specialist training required for this purpose is specified in the Directives. The length of training required varies between different specialties, but in some cases is shorter than that required in the United Kingdom for accreditation by a Joint Higher Training Committee. Accordingly doctors who have secured accreditation, and some doctors who are nearing it, can be treated as eligible for a Certificate of Specialist Training. Doctors who have been established as consultants in the relevant specialty for some time, but whose formal specialist training did not comply with the Directives, are usually eligible for a Certificate of Equivalence. This certificate, supported if neccessary by a Certificate of Specialist Practice, also enables a doctor to achieve recognition as a specialist in other EEC countries. Specialist certification at EEC level is not however of practical significance in relation to the present structure of medical practice in the United Kingdom.

It is interesting to compare the concept of free movement in the EEC with the traditional arrangements for "reciprocity" with other countries. Since 1886 there has been a substantial traffic both outwards and inwards under these arrangements. This system of reciprocity always involved a positive act of recognition by the Council of overseas qualifications. By contrast the obligations accepted by this country under the EEC Treaty are based primarily on political decisions. The Council has virtually no discretion as to which qualifications granted in other Member States it must accept and register. Because the Council viewed this prospect with anxiety it represented strongly that some system of quality control should be established to regulate medical education within the States of the EEC. As a result of these representations, which were supported by the British Government, an Advisory Committee on Medical Training has been established within the EEC. The Council was invited by the Government to nominate a member of this Advisory Committee – currently Professor J. N. Walton, the Chairman of the Council's Education Committee.

It remains to be seen how effective the Advisory Committee on Medical Training will prove to be. The situation which it faces is comparable to that which the General Medical Council faced when it was established in 1858. At that time the standard of medical qualifications granted in different parts of the British Isles varied widely, and it took the Council 30 years effectively to harmonise them. The task facing the Advisory Committee on Medical Training for the EEC is a formidable one. The Council is watching with great interest the progress of its efforts.

REGISTRATION OF OVERSEAS DOCTORS

by R. C. B. Gray
Assistant Registrar

Full and Provisional Registration

The Overseas Committee has continued its review of qualifications granted in overseas countries which are recognised by the Council, under the statutory provisions relating to reciprocity, for the purpose of full or provisional registration. In October 1976, a Council delegation visited the Medical School in Malta; their report recommended, and the Committee agreed, that the Council should continue to recognise the MD degree of the University of Malta for full or provisional registration. Repeated attempts to arrange a similar visitation to Makerere University were frustrated by a ruling of the President of Uganda and the Committee decided that degrees of MB ChB granted by Makerere University after November 1976 shall be recognised for temporary registration only. The number of qualifications granted by bodies overseas which are recognised by the Council for full or provisional registration has fallen from over 90 in 1970 to 23 at the present time. However, overseas doctors who qualified in India, Sri Lanka or Uganda before the dates from which recognition of medical degrees granted in those countries was withdrawn can still apply for full or provisional registration. During the last three years the numbers of overseas-qualified doctors granted full registration have continued to increase, as follows:

1974 – 1,930 1975 – 2,741 1976 – 3,133

The review of qualifications recognised for full or provisional registration continues and the Overseas Committee will shortly consider reports of a delegation which visited five medical schools in South-East Asia during January and February 1977.

Temporary Registration

Temporary registration is granted only in relation to specified posts in approved hospitals or institutions, and only for periods of up to twelve months at a time, although it can be extended for successive periods. Since June 1975 the Council has been prepared to grant temporary registration for the first time only to a doctor who has passed, or been exempted from, the tests of proficiency in English

and of professional knowledge and competence which are conducted on behalf of the Council by the Temporary Registration Assessment Board. The tests are designed to assess suitability to engage safely in practice in a British hospital in the grade of Senior House Officer. The categories of exemption, which were described in the Council's Annual Report for 1975, are related to the professional attainments of a doctor or to arrangements for his postgraduate training in this country under various types of sponsorship.

During the last four years the numbers of doctors granted temporary registration for the first time have been as follows:

1973 – 2,236 1974 – 2,391 1975 – 1,934 1976 – 1,021

The marked decline in first temporary registrations during 1976 can be attributed largely to the introduction of the TRAB tests. Of the 1,021 doctors granted temporary registration for the first time in 1976, 429 had passed the test and 592 had been exempted.

The total number of doctors practising in the United Kingdom under temporary registration also decreased during 1976, but to a smaller extent. On February 9, 1977 there were 6,555 entries in the Register of Temporarily Registered Practitioners, as compared with 6,912 on January 1, 1976. During 1976, a total of 11,989 certificates of temporary registration were issued.

The TRAB Tests

In 1975 the Temporary Registration Assessment Board instituted a review of the first full year of the TRAB tests. The Board completed its review during 1976 and published a report. This concluded that the first year of the tests had provided a valid assessment of the proficiency in English and professional knowledge of the candidates who had presented themselves and that the standard required to pass the test had been set at the correct level. Nevertheless, during 1976 the Board modified somewhat the form of the tests. From June 1976 the Modified Essay Question Paper was replaced by a Written English Paper, marked by linguistic examiners, and a Medical Short Answer Paper, of more traditional form, marked by medical examiners. The tests now comprise:

A. *Language Component*
I. Comprehension of Spoken English Test
II. Written English Paper
III. Part of an oral examination

B. *Medical Component*
IV. Multiple Choice Question Paper
V. Medical Short Answer Paper
VI. Part of an oral examination

In addition, the Board decided that, with effect from the test held in January 1977, a candidate who fails the test as a whole may be credited by the examiners with a pass in one component. Previously, candidates were required to pass both components of the test on the same occasion.

Twelve TRAB tests were held during 1976. Of 1,516 candidates, 510 passed. 550 of the candidates were attempting the test on a second or subsequent occasion. Despite the low pass-rate, the average numbers of candidates coming forward each month to take the tests for the first time has decreased only slightly, from 99 over the first year of the tests to 88 during 1976.

TRAB TESTS (January–December 1976, inclusive)

Schedule of results by country of qualification

Country of qualification	*No. of candidates*	*No. of passes*
India	376	142
Egypt	315	88
Iraq	254	105
Pakistan	92	24
Bangladesh	68	16
Greece	46	8
USSR	37	6
Nigeria	36	22
Sudan	33	26
Iran	37	3
Spain	22	5
Turkey	20	1
Poland	17	5
Syria	11	3
Italy	11	4
Brazil	10	2
34 other countries	129	50
	1,516	510

PROFESSIONAL DISCIPLINE

by R. S. R. Beers
Assistant Registrar

Summary of cases considered during 1976 by the Penal Cases Committee or by the Disciplinary Committee

The Penal Cases Committee

This Committee is responsible for deciding whether, or not, a case should be referred for inquiry by the Disciplinary Committee. If a case is not so referred, the Penal Cases Committee decides what other action, if any, should be authorised. Such action normally takes the form of a letter warning the practitioner either that the offence of which he was convicted in the Courts has been noted, or that his conduct appears to have fallen below the proper standard. The purpose of such letters is to give the doctor an opportunity to reconsider his habits or conduct.

The Penal Cases Committee held three meetings in 1976. Of the 111 cases considered by the Committee, 37 were referred to the Disciplinary Committee for inquiry.

The Penal Cases Committee noted a small increase in 1976, compared with recent years, in the number of convictions for dishonesty. These offences were mainly for shop-lifting, or travelling on the railway without paying the fare. The Committee also noted, however, a small decrease in the number of convictions involving an abuse of alcohol.

In regard to convictions in the Courts, the Council's pamphlet on Professional Conduct and Discipline includes the following advice:

> "Convictions of doctors are reported to the Council by the police and other authorities and, unless relating to minor motoring and other trivial offences, are automatically referred to the Penal Cases Committee . . . In considering convictions, the Disciplinary Committee is bound to accept the finding of the Court as conclusive evidence that a doctor was guilty of the offence of which he was convicted. It is not open to a doctor to argue before the Committee that he was in fact innocent of an offence of which he has been convicted. *It may therefore be unwise for a doctor to plead guilty* in a Court of Law to a charge to which he believes that he has a defence. A conviction in itself gives the Committee jurisdiction

even if the circumstances of the criminal offence did not involve professional misconduct."

The Disciplinary Committee

This Committee held three series of meetings, in March, July and again in November and December, in the course of which they sat on 30 days during 1976. In addition to the 37 new cases, the Committee also considered 24 other cases in which judgment or the finding had previously been postponed or the doctor's registration suspended. Restoration to the Register following disciplinary erasure was granted to 6 out of 9 applicants. In December one new case continued for 8 consecutive days and, for the first time, the Committee sat not only on Saturday, but also on Sunday, in order to complete the case.

Summaries of the cases considered by the Penal Cases Committee and by the Disciplinary Committee are provided in the following tables.

A number of these cases arose out of previous proceedings in the criminal Courts or by the National Health Service employing authorities.

The Council also received during the year a total of 930 complaints or letters about professional conduct from members of the public or the profession.

(a) Work of the Penal Cases Committee in 1976

Nature of Cases	*Cases considered*			*Cases referred to the Disciplinary Committee for inquiry*		
	Convictions	*Alleged Serious Professional Misconduct*	*Total*	*Convictions*	*Alleged Serious Professional Misconduct*	*Total*
1 Disregard of personal responsibilities to patients	—	5	5	—	2	2
2 Abuse of alcohol	19*	—	19	1	—	1§
3 Personal abuse of drugs	20†	5	25	8	2	10§
4 Non bona fide prescribing or supplying to others of drugs of addiction	2	8‡	10	2	3	5
5 Sexual relationship with patient	—	6	6	—	6	6
6 Dishonesty	16	2	18	3	—	3
7 Violence	1	1	2	—	—	—
8 Indecency	4	1	5	4	—	4
9 Advertising or canvassing	—	2	2	—	—	—
10 False certification or forging qualifications	1	1	2	—	1	1
11 Other charges	5	3	8	1	1	2
Total:	68	34	102	19	15	34

* Includes one case adjourned from 1975 and further adjourned to 1977.

† Includes three cases adjourned from 1975 and four other cases adjourned to 1977.

‡ Includes three cases adjourned to 1977.

§ One case in each category was referred, on different charges, for inquiry by the Disciplinary Committee in 1975.

(b) Work of the Disciplinary Committee in 1976

Nature of Cases	*Cases considered*			*Determination of the Disciplinary Committee*			
	Convictions	*Alleged Serious Professional Misconduct*	*Total*	*Erasure*	*Suspension*	*Postponed Judgment*	*Case concluded*
1 Disregard of personal responsibilities to patients	—	2	2	—	—	—	2
2 Abuse of alcohol	3	—	3	—	1	—	2
3 Personal abuse of drugs	14	3	17	1	1	6	9
4 Non bona fide prescribing or supplying to others of drugs of addiction	2	4	6	3	1	—	2
5 Sexual relationship with patient	—	6	6*	—	3	1	—
6 Dishonesty	5	1	6	—	1	1	4
7 Indecency	5	—	5	—	1	3	1
8 False certification or forging qualifications	1	—	1	1	—	—	—
9 Other charges	1	1	2	—	—	—	2
Total:	31	17	48†	5	8	11	22

* Includes two cases adjourned to 1977.

† Includes 14 cases on which judgment was postponed in 1975.

Complaints against doctors

The vast majority of complaints concerning the conduct of individual doctors, which are received either from members of the public, or from other doctors, are not of a sufficiently serious nature to justify the institution of disciplinary proceedings. These complaints are therefore not referred to the Penal Cases Committee. Instead, they are considered by the President and he sanctions the replies which are subsequently sent to the complainants. In a number of instances such complaints are indicative of conduct which is not in the best interests of a doctor's patients and which the doctor would be well advised to eschew. For example, following a complaint by one of his patients, a general practitioner was advised that he should ensure that the manner in which he was assisted by any lay person, such as

his practice manager, should not be such as to give members of the public the impression that the person concerned was medically qualified.

Many doctors write to the Council for advice on matters of professional conduct. It is often difficult for the Council to give specific advice on questions of this kind because one of its main statutory functions is the exercise of disciplinary jurisdiction over doctors. Nevertheless, the Council provides guidance whenever it is possible to do so, bearing in mind its statutory responsibilities. For example, a doctor sought advice on questions concerning the referral of patients to a chiropodist. The doctor was advised that the Council did not wish to restrict the use by doctors of persons who have been trained to perform specialised functions from carrying out treatment or procedures falling within the proper scope of the skills of such persons, provided that the doctor concerned retains ultimate responsibility for the management of the patient. In such cases, however, it is implicit that there may be some condition in the patient requiring supervision or management by the doctor. If, therefore, the doctor refers the patient to a chiropodist, it is the responsibility of the doctor to satisfy himself that the chiropodist is a proper person to deal with the condition and the individual chiropodist is given adequate instructions as to the treatment which is necessary in that particular case.

KEEPING THE REGISTER

by J. Pedley
Assistant Registrar

"The Register shall continue to be kept . . . and shall contain . . .": so runs the legislation. Apart however from specifying that names, qualifications, addresses, and dates of registration of persons on it shall be included, and that it shall comprise a Principal and an Overseas List, the law leaves everything else to be prescribed by Regulations. It is remarkable how much else there turns out to be that needs to be done in order that the Registrar shall properly discharge the duty imposed upon him "to keep the Register correct". Anyone who might be inclined to suggest that the Register of Medical Practitioners could adequately be maintained as a subsidiary operation to that undertaken in respect of another list or lists already maintained for other purposes might be surprised at the number and variety of the "transactions" (to use the jargon) involved in keeping a correct Register.

At the end of 1976, there were 131,316 fully registered doctors on the Register – 98,186 were on the Principal List and 31,130 on the Overseas List. In addition, there were 5,467 provisionally registered doctors on the Register. Throughout 1976, these registered medical practitioners gave rise to not far short of 65,000 "transactions" of some sort or another – in other words, something had to be done to the Register Entry of almost every other registered practitioner. During 1976, 3,423 were granted provisional and 6,181 full registration. 15,926 changed their address on the Principal List, which is usual, and nearly 6,000 changed their address on the Overseas List – an unusual phenomenon which resulted from a special operation to correct that List. 3,112 applied for transfer to the Overseas List; 1,252 died; 1,183 were erased for non-payment of their retention fees, and 289 under provisions in the Medical Acts which permit the removal from the Register of the entries of doctors who do not reply to letters and have apparently ceased to be interested in remaining registered. Restorations of non-payers totalled 647 and of "lost contacts" 118. Finally (and at first sight alarmingly) there were 29 "changes to sex indicator". This however betokens the fact that at some time in the past a doctor's sex had been erroneously divined on registration, a process not made any easier in recent years, parti-

cularly in relation to doctors with foreign names, by the abandonment of a requirement that women applicants for registration should indicate either "Miss" or "Mrs" for entry in the Register.

"All things are in a state of flux," said Heracleitus: he might have had the Register in mind. The task of keeping this constantly changing and complex entity correct and accurate demands constant vigilance. The members of the staff of the Council who deal with the myriad "transactions" involved necessarily take some time learning the job; and some of these are people who are not disposed to spend more than a year or two with the Council before moving on to other fields. Having become familiar with all the wrinkles off they go: and someone then has to be trained from scratch to replace them. Inevitably therefore a few cases of inaccuracy in the Register as a result of insufficient care or lack of experience by someone in the Council's office come to light – often on the advice of the doctor concerned, who has had the good sense to return some certificate or other sent to him by the Council which shows a mistake in his Register entry. Like the chocolate makers who so "gladly replace" an imperfect block, we too welcome consumer feedback as a means of maintaining the standard of the product.

FINANCE

The following summary shows the main items of the Council's income and expenditure in 1976:

	Income £		*Expenditure* £
Annual retention fees	549,328	Education	42,451
Fees received on provisional or full registration:		Professional conduct and discipline	109,504
British and Irish doctors	76,050	Registration of British and Irish doctors	33,935
Overseas doctors	110,795	Maintenance of Register	57,792
Fees received for temporary registration of overseas doctors	154,830	Registration of overseas doctors	138,944
Fees received from candidates for the TRAB tests	50,442	TRAB tests	91,738
Fees received for EEC certificates	91	Collection of annual retention fees	101,575
Sales of Medical Register and Fortnightly Lists	37,278	Printing of Medical Register and Fortnightly Lists	37,034
Other sources including net investment income	40,822	EEC activities	9,952
		General administration	313,070
TOTAL	£1,019,636	TOTAL	£935,995
		Appropriated to staff superannuation fund in respect of renewed past service liability	13,068
	£1,019,636		£949,063

Most of the foregoing items are self-explanatory: the heading "General administration" represents all expenditure which it would be unrealistic to apportion among other headings shown in the summary, including such items as meetings of the Council, cost of staff employed on common services, expenses of conducting an election of members to the Council and all expenditure on premises: the last named ingredient was substantial. In 1975 the Council had been in deficit, but in 1976 the income of the Council increased by £236,605. Of this increase £167,075 came from the annual retention fee which was increased from May 1976 from £5 to £8. Fees paid by overseas doctors for full, provisional and temporary registration and

fees paid by candidates for the TRAB tests increased by more than £52,000. The income from sales of publications increased by more than £7,000.

During 1976 the expenditure of the Council rose by £146,816 as compared with 1975. A substantial part of this increase reflects the continuing pressure of inflation. 1976 was the first *full* year in which the TRAB tests were held, and these cost £91,738. This was met partly by fees paid by candidates (£50,442) and the remainder (£41,296) from fees charged for temporary registration. During 1976 the Council had to meet expenditure of £9,952 arising from new activities in connection with the implementation of the EEC Directives.

By the close of the year, income had exceeded the Council's ordinary expenditure by £83,641. Of this immediate surplus, £13,068 was appropriated to the staff superannuation fund in respect of a renewed liability arising from the effect of inflation on superannuation benefits. The rest of the surplus was transferred to the General Reserve. The net assets of the Council on December 31, 1976 were still less than half of its annual expenditure.

It is hoped to avoid an increase of the annual retention fee in 1977 but if inflation continues it will not be possible to stabilise the fee indefinitely.

Copies of the Council's accounts for 1976 may be obtained from the Registrar.

PERSONALIA

An election of the 11 elected members of the Council took place in April 1976. All the members who stood for re-election were elected. Five members did not stand, Dr William Fulton, Dame Frances Gardner, Dr Derek Llewellyn, Dr Gordon McAndrew and Mr Evan Arthur Williams. All had been members of the Council since April 1971, and all had played an active part on committees. Dr Fulton in particular had served on all the statutory and standing committees of the Council. The newly elected members are Dr W. J. C. Scott, Mr S. C. Simmons, Mr P. R. J. Vickers, Mr R. J. Williams, Dr J. Winter and Dr A. W. Wright.

The Council lost two members through retirement, Professor Robert Roaf who represented the University of Liverpool from October 1, 1970 to September 30, 1976, and Dr Alastair Hunter who represented the University of London from January 1, 1972 to December 31, 1976. New members appointed in their place by the Universities of Liverpool and London are Professor K. McCarthy and Professor A. H. Crisp.

The year saw the deaths of four former members: Professor Daniel Cappell who represented the University of St Andrew's from 1940 to 1945, and the Royal College of Physicians and Surgeons of Glasgow from 1960 to 1970; Professor Henry Miller who represented the University of Newcastle upon Tyne from 1966 until 1968; Dr Eric Arthur Gerrard, an elected member of the Council who served from 1966 until 1971; and Dr John Gibb McCrie who represented the University of Sheffield from 1947 to 1972, and was Treasurer and eventually Senior Treasurer from 1965 to 1972, and chaired the Disciplinary Committee on occasions.

CHANGED YOUR ADDRESS?

This Report is being sent to practitioners at the addresses shown in their entries in the Register on April 15, 1977. 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 to the Council's office at 44 Hallam Street, London, W1N 6AE.

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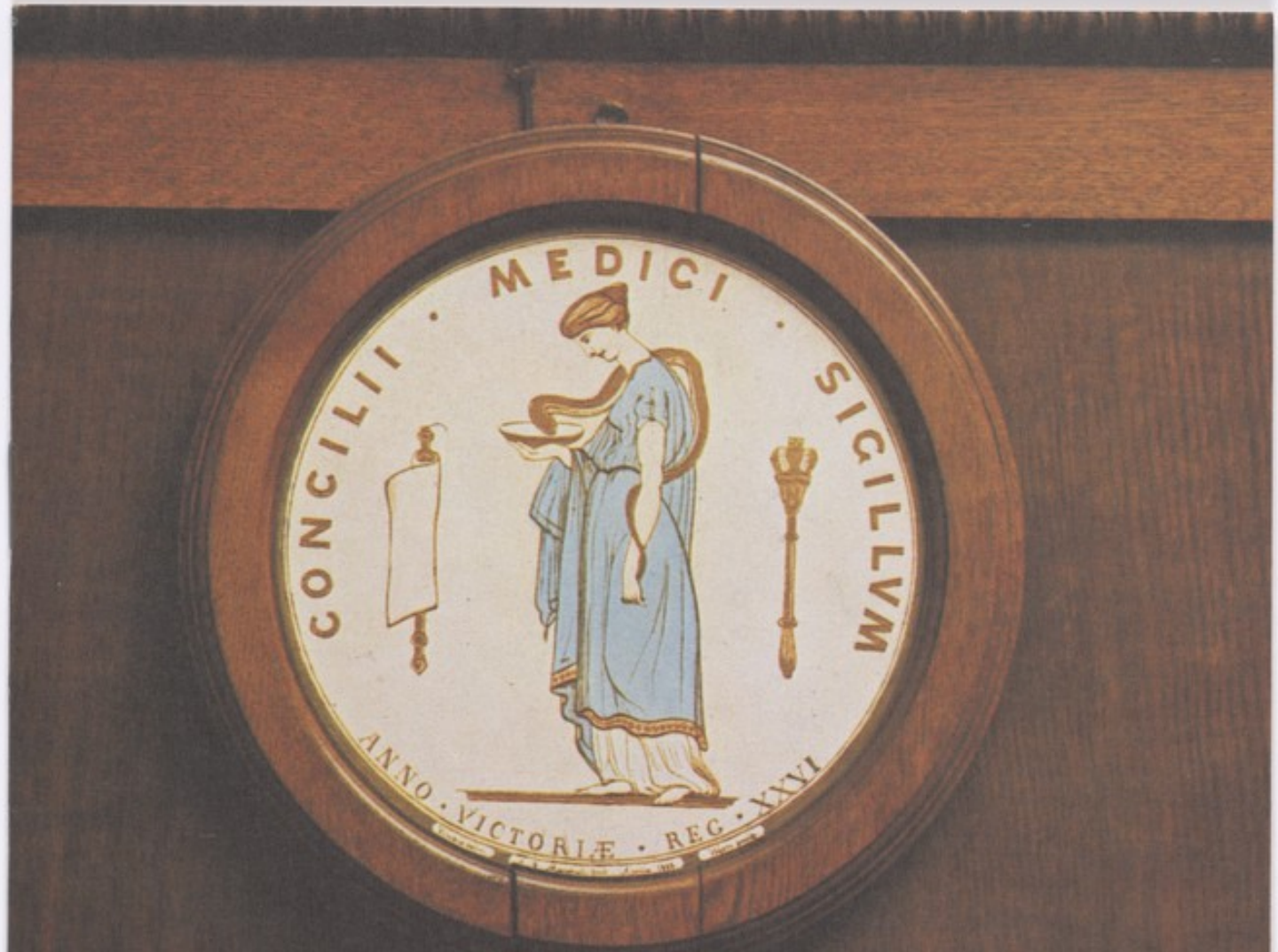

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1976

March 1977