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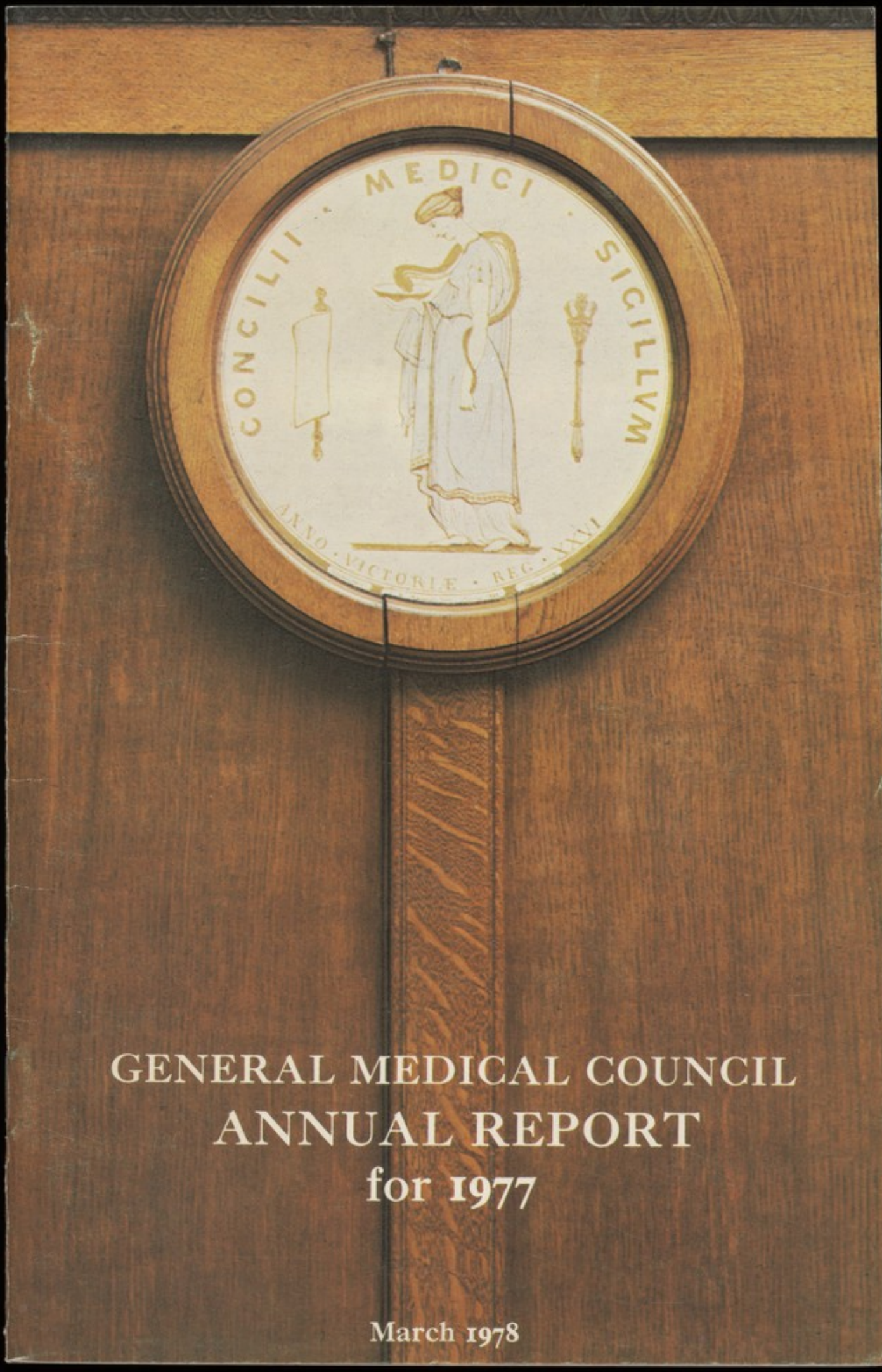

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1977

March 1978

THE GENERAL MEDICAL COUNCIL

March 1978

President

SIR JOHN SAMUEL RICHARDSON Bt MVO FRCP Lond

Members

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LEGISLATION AND THE GMC

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

At the time of writing this article at the end of February, 1978, a Medical Bill is before Parliament which, if enacted, will make great changes in the composition and the powers of the GMC. Some doctors seem to think that because the Council is called the *General* Medical Council it can do anything it chooses. In fact what the GMC can do is determined by legislation, though of course it has discretion within its stated powers. If the GMC were like the Councils for Postgraduate Medical Education and worked only by consent, its functions would not be limited by the law, but the GMC's position is different. Doctors are, through the fact of their registration, given certain privileges in law — for example, only registered medical practitioners may be employed in the National Health Service or recover their professional charges in the Courts or sign prescriptions for controlled drugs. These privileges are conferred by law and it follows that the granting of registration must be similarly controlled.

The Medical Bill now before Parliament is based largely upon the Merrison Report. That report recommended substantial changes in the arrangements for regulating medical education, and in the arrangements for the registration of overseas qualified doctors, and proposed new arrangements for dealing with doctors whose fitness to practise had become seriously impaired by physical or mental ill health. It also proposed substantial changes in the composition of the Council with a majority of elected members and an increase in the number of lay members.

The Medical Bill which the Government introduced into the House of Lords last November dealt only with some of these recommendations — principally the composition of the Council and arrangements for the "sick doctor". But I am glad to say that during the passage of the Bill through the House of Lords its scope was substantially extended, both in relation to medical education and to the arrangements for the registration of overseas qualified doctors.

The present Council has repeatedly expressed the view that the whole of the Merrison Report should be implemented. The

Council therefore welcomed the broadening of the scope of the Bill, but since, at the time when I write, the Bill has still to go through the House of Commons with the possibility of further changes, I will refrain from prophecy as to its final shape.

The Council will do all that it can to hasten the bringing into effect of the various changes for which the Bill may provide, but this process will inevitably take some time. Before the reconstituted Council can meet the Privy Council will need to make an Order defining precisely the number of members to be elected, or appointed by the Universities and Colleges, or nominated by the Crown: the Privy Council will also have to appoint the succession day on which the new Council will take office. Before the new Council can sit the present Council must, after consulting bodies representing medical practitioners, draw up an electoral scheme for the election of the elected members. This scheme will then require to be approved by the Privy Council and an election under it will then have to be held. All these processes will take a considerable time — perhaps eighteen months or so after the Bill receives the Royal Assent. Some of the other changes for which the Bill provides will take even longer. For example, the new machinery to deal with the sick doctor cannot be established until the new Council has, again after consulting bodies representing medical practitioners, drawn up Rules of Procedure for the new Health Committee and also for the new Preliminary Proceedings and Professional Conduct Committees which will replace the present Penal Cases and Disciplinary Committees. These Rules will require to be approved by the Privy Council which will then have to appoint further days for the new Committees to begin to exercise their powers. The same is true in the field of medical education where the new Council will need to appoint an Education Committee to which the educational powers of the present Council will be transferred, together with new powers conferred by the Bill.

I wish it were possible in the present Annual Report to give you a more comprehensive account of what will happen under the Medical Bill, but until it has passed through Parliament and received the Royal Assent, any attempt to do so would involve speculation. I will, however, undertake in the Council's next Annual Report to give you not only a full account of the forthcoming changes, but a clearer indication of when each of them seems likely to be accomplished.

MEDICAL EDUCATION AND AN ELECTED MEMBER

by John Fry, OBE, MD, FRCGP

I was first elected to the General Medical Council in 1970. As a new boy I walked down Hallam Street to my first Council meeting with awe and an almost total lack of knowledge and understanding of its work. I believed that its chief occupation was to sit in judgment over unfortunate colleagues. I imagined it to be an aloof, remote, autocratic and bureaucratic body. How wrong I was! Its medical members are a cross representation of the profession, but with a preponderance from medical schools. The staff are able, sincere, humane and approachable.

Set up by law in 1858 it was, and is, there to try to ensure that the public is served by doctors who are well educated and trained and who, once in practice, conduct themselves well in the care of their patients.

The supervision of undergraduate education and the curriculum, therefore, are important tasks for the Council. It carries these out through the Education Committee.

Education Committee

It may be wondered what an elected member, and a general practitioner at that, can contribute to the Education Committee and what is there of interest and importance? There is much that he can contribute and there will be much more in the future in the new Council.

It has been the custom of the Council to produce "recommendations" on medical education every 10 years or so. The last two sets of recommendations in 1957 and 1967 have moved away from setting down firm curricular criteria, towards encouraging broader and more flexible guidelines for medical schools. In the 1967 recommendations the need to teach more of general practice and of behavioural sciences was noted specially. Medical education as a continuum extending well beyond the undergraduate period was stressed also.

Over the past 7 years there has been much in the work of the Committee to involve me as a general practitioner elected

member of the Council. Three new medical schools, at Nottingham, Southampton and Leicester, have been developing, and general practice and its allied disciplines have received a greater than usual part in their curricula. Older well-established medical schools are introducing much more flexible curricula for their students and there have been opportunities to put forward the needs of future general practitioners.

The Council also examines undergraduate curricula of medical schools overseas, for them to receive approval for temporary or full registration for their graduates. It is a fascinating experience to see the various means by which attempts are made to achieve similar end products, i.e., well trained graduate doctors.

For example, medical schools in New Zealand are finding it possible effectively to reduce the length of their curricula by allowing their final year students to act as responsible clinicians caring for patients in wards under strict supervision. This must raise the question of the length of our undergraduate training period. Is it too long and are curricula too stuffed with attempts to teach too much? Could we cut the customary 3-year clinical undergraduate period and replace it by a more structured 2-year pre-registration period?

One of the Council's group of 'visitors' to developing countries in Asia reported back on the emphasis placed in undergraduate teaching on the medical profession's duties and responsibilities beyond the purely clinical sphere. Teaching emphasises the need to conserve resources, to provide equal distribution of health care to rural areas and to implement preventive principles. We might consider applying this teaching to our own needs to make better use of our resources.

Survey of Basic Medical Education

In 1977 the Council's Survey was published. Involvement in its planning and analysis of its results have provided further opportunities to view our medical education and its needs for the future in the light of the results of the Survey. Volume 1 shows what the medical schools are doing and Volume 2 gives an account of the various disciplines and specialties, including general practice.

The Section on general practice teaching shows what has been achieved; every medical school includes general practice in its curriculum and by 1980, it is stated, all will have departments of general practice. However, it is also apparent that these new

departments are facing major problems of identity, of objective definition, of teaching methods, of roles and duties for their academic teachers and of acceptance by the rest of the faculty.

The general practitioner members on the Education Committee have special responsibilities to keep a constant watch on developments in these new fledgling departments of general practice, and to be ever ready to support them.

Conferences

Since 1972 there have been one or two conferences each year on educational subjects, such as undergraduate medical education, its objectives and methods of assessment, on the pre-registration year, on the teaching of psychology and sociology and on teaching in general practice.

The conference on teaching in general practice in the undergraduate curriculum (the Council has no powers to supervise vocational training) in 1974 anticipated the findings of the Survey. The main speakers were general practitioner undergraduate teachers. They set out their plans and achievements but they were subjected to much critical questioning from non-general practitioner academics, and the gulf revealed between the two groups was one that has to be bridged. This is another task of interest to the Council.

These conferences at 44, Hallam Street, have brought together many of those involved in medical education, they have given their views on subjects selected by the Council and these views and opinions have been of great value in planning for the future.

Expanding Roles for General Practice

Most recently there is discussion within the Education Committee of possible expanding roles for general practice. It has been proposed to the Committee that a small number of pre-registration general practice appointments be approved as an experiment. These would be organised by academic departments of general practice in teaching health centres. To achieve such experiments will require considerable persuasive efforts.

Why a GP on the Education Committee?

I believe it is very necessary for elected general practitioner members to serve on the Education Committee for a number of reasons.

First, they are needed to give a true balance of perspective and proportion to the educators and academics on the Committee. Academics must be reminded constantly that one-half of their medical students will end up as general practitioners.

Secondly, general practice is a specialty, with its own skills and core of knowledge, just as much as paediatrics, surgery or neurology. Colleagues in other specialties need to be educated and informed about general practice, even in the confines of the GMC Education Committee. It is never too late! Voices must be raised to ensure its proper place in the curriculum and to ensure that the academic departments of general practice are adequately staffed and supported.

Above all, elected general practitioners have the privilege of serving general practice on Council and opportunities to create added respect for their specialty.

A feature of the work of the Council in general, and of the Education Committee in particular, is the friendly cooperation that takes place between all its members, elected and non-elected. Within the Education Committee there is close harmony between the "academics" and the general practitioners. The interplay of contributions has one purpose, to improve the standards of British medicine, and although the various members of the Committee have a great diversity of experience its work becomes unified and creative to achieve this objective.

During these 7 years I have had the great experience of representing the profession on Council as an elected member under two progressive Presidents, the late Lord Cohen and Sir John Richardson, and two stimulating Chairmen of the Education Committee, Sir John Brotherston and Professor John N. Walton.

The future, in the aftermath of the Merrison Report, promises even more exciting work for general practitioners on the Education Committee.

VISITING OVERSEAS

by William Ivor Neil Kessel, MD, FRCPsych

Professor Kessel went to Malta in 1976, and to Singapore, Malaysia and Burma in 1977, as a member of a GMC visiting team

A GMC visit to an overseas medical school to recommend whether its graduates may continue to enjoy their traditional access to the permanent Medical Register is a most enjoyable engagement, unpaid but fully found and no sinecure. A long working day was usually followed by eagerly offered and warmly accepted hospitality. The pleasures lay in the courtesy with which we were everywhere received and in the excitement of sharing ideas, in new surroundings with so many varied, lively and likeable medical men and women. There were, too, the weekends; indeed one Sunday afternoon the Chairman of the Overseas Committee was heard to agree, while cruising up the Irrawaddy, that this had not been within his expectations when he passed the Fellowship.

A visit to a medical school generally took three days, starting by meeting the Vice-Chancellor, then sitting down with the Dean and department heads discussing every aspect of activities from student selection to the final examination and the internship year.

Members of the team then visited each department, hearing the professors and senior staff outline the syllabus, its objectives and how it was taught, watching lectures, practicals and tutorials, attending ward rounds and closely observing the group around the bedside, its size and the extent of student participation. If the students sometimes found it an ordeal to explain just what they saw down the microscope or heard through the stethoscope they always did their venturesome or shy best. We obtained a good idea how bright were the students and how stimulating the course. I guess that my own medical school would pass such a scrutiny; it would be salutary to have similarly to explain the purposes of our curriculum and the precise procedures for its review and revision. Nowhere were we told directly of professorial *force majeure*. *Suppressio*, one might think, *veri*, but we were men of the world and it came out often enough in our concluding meetings with the staff.

In countries with largely rural populations an important section of the teaching went on in village centres. As we followed the teaching, everywhere we saw medical team work as a component of village life. I vividly remember sitting on the floor of a Burmese schoolroom watching students conduct medical examinations and nurses giving health education lessons. Social medicine programmes involving students spending some months in small communities are a feature of many Far Eastern medical schools and the emphasis on preventive medicine is enviably greater than that given to British students.

One difficulty we encountered was when medical schools, so great was the country's need for more doctors, had greatly expanded student intake without being able to provide a concomitant increase in staff or in clinical facilities. We were discouraged by the consequent decline in personal participation in laboratory experiments and in individually obtained clinical experience.

We often sensed an unfortunate but understandable tension between Governmental pressure to make medical education befit doctors for work in rural areas with minimal technical support, and the wish of academic teachers to preserve the unity of medicine as a world-wide commonality of thought and practice. This was a dismaying dilemma for the GMC visitors. Our primary task was to judge whether the doctors being produced were soundly enough trained for practice in Britain; yet we clearly saw that each country wished to train doctors appropriate to its needs and the available level of medical care provision. Fortunately we found that those best trained for practice in their own country had the broadest understanding of medical principles, appropriate to practice anywhere.

A related difficulty concerned language. The GMC expects a working knowledge of English and so do the academic staff, since it is the language of textbooks and journals. However, it is hard enough to encompass the curriculum in five years without having as well to learn a foreign language and then study in it. We discovered, too, the artificiality of taking a history in one tongue and presenting it in another. Moreover, those with sufficient English to begin training were often not a cross-section of school leavers wanting to and able to study medicine; in particular they seemed to include a disproportionate number less willing to go

into the Governmental Health Service or to practise outside the cities. Also, since GMC recognition gave access to practise in a number of countries, the way was open for a loss of sorely needed doctors; conversely, failure to receive recognition might well result in more doctors remaining to serve the country. To all this the GMC is officially blind, but of course the individual visitors were well aware of it and we too were interested in separating the would-be emigrant from the genuine postgraduate student intending a short stay overseas. We were glad that, however they stood in respect of full registration, graduates of the medical schools concerned would be able to apply for temporary registration and thus we might continue to offer to their many talented graduates the opportunity to come to these islands and further their experience.

Wherever we went we were impressed with the quality of medical students and young doctors. All over the world it seems that the best qualified of school leavers want to study medicine. So long as this is so the future of medicine appears bright. Your correspondent, indeed, feels a sense of shame in relating the very evident eagerness and sensibility of the young doctors he met with the sometimes lost and wistful look they have when visiting this country for clinical experience. He found himself determined to make them as welcome here as they made us during our visits.

REGISTRATION OF OVERSEAS DOCTORS

Full registration

The numbers of overseas-qualified doctors granted full registration fell from 3,133 in 1976 to 2,800 in 1977. The downward trend reflects a reduction of 29% in registrations of doctors with qualifications obtained in India and Sri Lanka before May, 1975, and February, 1972, respectively. Recognition for full registration has been withdrawn from medical degrees granted in those countries since those dates. The reduction was partially offset by an increase in applications for full registration from doctors who had qualified in other overseas countries, particularly Australia.

The Overseas Committee has continued to review those qualifications which when currently granted are still recognised for full registration. A delegation visited five medical schools in South-East Asia on behalf of the Council during January and February, 1977. In the light of their report the Overseas Committee agreed to continue to recognise for full registration medical degrees granted by the University of Singapore and, for a period of five years only, the MB BS degrees granted by the University of Malaya in Kuala Lumpur. The Committee decided that MB BS degrees granted after May 26, 1977, to students of the three Medical Institutes in Burma should be recognised for the purpose of temporary registration only.

Following receipt of information of events in Malta which had affected clinical teaching and hospital practice in the islands, the Overseas Committee suspended recognition of degrees granted by the University of Malta after July, 1977. Recognition for full registration of qualifications granted in the Canadian Province of Nova Scotia was also terminated in October, 1977, following the withdrawal by that Province of reciprocal privileges of practice for British qualified doctors.

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. Since June, 1975, the Council has been prepared to grant temporary registration for the first time

only to doctors who have passed or been exempted from the tests of proficiency in English and of professional knowledge and competence conducted by the Temporary Registration Assessment Board.

The Overseas Committee has instituted a review of the overseas qualifications which are recognised for temporary registration. Over the last thirty years the Council has recognised for this purpose qualifications granted in 80 countries. Because it is not practicable to visit the medical schools where doctors are trained for these qualifications, the review is being conducted on the basis of documentary evidence of their curricula, staffing establishments, and facilities for teaching. To date, the Committee has reviewed the qualifications granted in six countries.

The number of doctors working under temporary registration in the United Kingdom decreased during 1977. On January 1, 1978, there were 5,982 entries in the Register of Temporarily Registered Practitioners, as compared with 6,555 on February 9, 1977. During 1977, 11,086 periods of temporary registration were granted, including 1,124 to doctors who were being granted temporary registration for the first time. Of these, 483 had passed the Temporary Registration Assessment Board test and 641 had been exempted. 166 doctors were exempted from the test because they had qualified in a country where English is the primary language, in a medical school where English is the language of instruction, or because they held additional registrable qualifications such as the MRCP. 168 other doctors were exempted because before their arrival in the United Kingdom they had been appointed to hospital or academic posts in the grade of Registrar or equivalent or above. 48 applicants for temporary registration with EEC qualifications were also exempted, from both the language and medical component of the test. In 255 other cases the exemption was limited to temporary registration granted in respect of either training appointments arranged for postgraduate fellows or scholars by a sponsoring body or to posts in a specialty for which the applicants were particularly qualified by previous experience and training. In the four remaining cases the practitioners were exempted on the grounds of their professional attainments, without limitation, by Committee decision.

From the outset, the Council has sought to monitor the effectiveness of the Temporary Registration Assessment Board

tests by obtaining confidential reports on the performance in their first appointments under temporary registration of doctors who had passed them. At the same time, the Council has monitored its procedures for exempting certain categories of doctors from the tests by obtaining reports on the performance of those exempted. Up to January 31, 1978, adverse reports had been received on 1·6% of the doctors who had been granted temporary registration after passing the test and on 0·37% of the exempted doctors.

The TRAB test

The Temporary Registration Assessment Board conducted eleven tests during 1977. Of 1,663 candidates, 532 passed: 676 of the candidates were attempting the test on a second or subsequent occasion.

TRAB TESTS (January—December, 1977, inclusive)

Schedule of results by country of qualification

Country of qualification	*No. of candidates*	*No. of passes*
India	421	142
Egypt	389	107
Iraq	246	109
Pakistan	85	22
Nigeria	73	30
Bangladesh	58	9
Iran	57	8
USSR	43	7
Syria	34	4
Sudan	25	21
Greece	22	7
Poland	21	3
Sri Lanka	20	14
Italy	14	2
Nationalist China	13	4
Spain	11	3
Turkey	11	1
Yugoslavia	11	3
34 other countries	109	36
Total	1,663	532

PROFESSIONAL CONDUCT AND DISCIPLINE

The Council elects annually from its members those who are to serve on the Penal Cases Committee and the Disciplinary Committee for the ensuing twelve months. No member can serve on both Committees contemporaneously, nor can any member of the Penal Cases Committee become eligible for election to the Disciplinary Committee until a year has elapsed since he ceased to be a member of the former Committee. A system of rotation is observed so that no member can continue to serve on either Committee indefinitely. The electoral scheme provides that each Committee will include elected and lay members.

Summary of cases considered in 1977

(a) *The Penal Cases Committee*

The Committee considers written evidence only. This may be an official notification that a doctor has been convicted of a criminal offence in a court in the United Kingdom, the Republic of Ireland, the Channel Islands, or the Isle of Man, or it may comprise allegations set out in one or more statutory declarations by complainants, or derived from information received from a person acting in a public capacity such as an officer of one of the Health Departments or the Home Office, which suggest that a doctor may have committed serious professional misconduct. In conduct cases, the doctor is provided with copies of any statutory declarations or information, and invited to forward for consideration by the Committee any explanation which he may wish to offer on the matters alleged against him. Beginning during 1977 doctors convicted in the courts have also been invited to forward observations on their conviction if they so wish.

The Committee held three meetings in 1977 and considered 105 cases of conviction or conduct. It referred fifteen cases for inquiry by the Disciplinary Committee and directed that a letter conveying an appropriate warning should be sent to the doctors concerned in 76 other cases. In twelve cases, the Committee directed that no action should be taken, and in the two remaining cases consideration was postponed until 1978 in order that further inquiries could be made.

The Committee noted a small increase in 1977, compared with recent years, in the number of convictions for offences involving

dishonesty. These were mainly for shoplifting. The Committee found some difficulty in understanding why the doctors concerned, a few of whom were senior members of the profession, should have behaved in such a way. In regard to cases of conduct generally, there was no significant increase or decrease.

There was a considerable range of offences among the cases referred to the Committee. For example, there was a conviction for "depositing poisonous waste" — or in other words depositing some surplus drugs on a municipal refuse tip.

One unusual case was brought to the attention of the Committee in 1977. It involved a medical officer of H.M. Forces who had been found guilty by Court Martial on two charges of desertion. The officer had entered into an undertaking whereby he had agreed that, in consideration of financial assistance towards the completion of his training as a medical cadet, he would continue to serve as a commissioned medical officer for a further period of not less than five years after obtaining full registration as a medical practitioner. He subsequently failed to honour that undertaking. The Committee were given to understand that the doctor, following his conviction by Court Martial, was undertaking the service required of him, and decided that it would be sufficient to warn him as to his future conduct.

A summary of the cases considered by the Penal Cases Committee is provided in Table A on page 16.

(b) *The Disciplinary Committee*

This Committee normally sits in public as required by its Rules of Procedure. In 1977 the Committee held meetings in March, July and November on nineteen days. One of the fifteen new cases referred to it for inquiry was postponed until 1978 owing to the illness of the doctor concerned. The Committee therefore considered fourteen new cases and two other cases which had been adjourned from 1976, and in addition reconsidered thirteen cases on which judgment was postponed or a period of suspension was imposed in 1976. Restoration to the Register following disciplinary erasure was directed in three out of eight cases considered.

In recent years the Council has taken disciplinary action in a number of cases where a doctor had been convicted of offences involving an abuse of drugs, or where it was alleged that he had committed serious professional misconduct by prescribing drugs otherwise than in the course of bona fide treatment. In 1977, ten

such cases were considered or reconsidered by the Disciplinary Committee. Powers vested in the Home Office under the Misuse of Drugs legislation provide a procedure whereby a doctor who has been convicted of an offence involving controlled drugs may, by Order of the Secretary of State, be prohibited from administering, supplying or prescribing such drugs. Since 1974, similar powers have been available in cases where a doctor is judged by a Tribunal, convened by the Home Office for the purpose, to have prescribed controlled drugs irresponsibly. The Council has made representations to the Home Office on a number of occasions that they should, in the public interest, make more frequent and effective use of the Tribunal procedure so that the public interest may be protected without depriving the doctor of his livelihood by suspending his registration.

In 1977, the Penal Cases Committee referred for inquiry one case in which it was alleged that a doctor had committed serious professional misconduct on the grounds that he had disregarded his responsibilities to his patients. In particular, it was alleged that he had (a) personally failed to visit or treat a number of patients when requested to do so and their condition so required, (b) cancelled or curtailed his surgery on a number of occasions without giving prior notice and without making adequate arrangements for treatment to be given to his patients attending and requiring medical attention, and (c) improperly instructed a nurse to give injections to patients whom he had neither seen nor examined. These allegations were proved to the satisfaction of the Disciplinary Committee who directed that the doctor's registration should be suspended for twelve months.

Another case considered by the Disciplinary Committee in 1977 concerned a doctor who had been convicted of driving a motor vehicle when the proportion of alcohol in his blood exceeded the prescribed limit. In addition, it was alleged that he had committed serious professional misconduct in that, during numerous and recurrent periods over a number of years, he had abused alcohol to such an extent as to affect his fitness to practise and in consequence he had failed to attend patients either at his surgery or in their homes when he was under the influence of alcohol. The doctor was found guilty of serious professional misconduct by the Disciplinary Committee who postponed judgment in order to keep the doctor under their surveillance.

(A) **Work of the Penal Cases Committee in 1977**

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	—	2	2	—	1	1
2 Abuse of alcohol	23*	1	24	2	1	3
3 Personal abuse of drugs	14†	4§	18	4	—	4
4 Non bona fide prescribing or supplying to others of drugs of addiction	—	4	4	—	1	1
5 Personal relationship of an emotional or sexual nature with a patient	—	3+	3	—	1	1
6 Dishonesty	20	2	22	2	1	3
7 Violence	2	—	2	—	—	—
8 Indecency	5	4	9	—	—	—
9 Advertising or canvassing	—	6	6	—	—	—
10 False certification	—	2	2	—	—	—
11 Other charges	9	4‡	13	1×	1	2
Total:	73	32	105	9	6	15

* Includes 1 case adjourned from 1976
† Includes 3 cases adjourned from 1976
‡ Includes 1 case of fraudulent and incorrect entry in the Register
§ Includes 3 cases adjourned from 1976
\+ Includes 1 case adjourned to 1978
× An inquiry by the Disciplinary Committee in this case was postponed to 1978

A summary of the work undertaken by the Disciplinary Committee is provided in Table B on page 17. A number of cases involved more than one element. For example, the case described in the foregoing paragraph involved a disregard of personal repsonsibilities by a doctor to his patients. However, the cause of this was an abuse of alcohol and it is under this heading in the table that the case is included.

(B) Work of the Disciplinary Committee in 1977

Nature of Cases	Cases considered			Determination of the Disciplinary Committee			
	Convictions	Alleged Serious Professional Misconduct	Total	Erasure	Suspension	Judgment Postponed	Other Action
1 Disregard of personal responsibilities to patients	—	1	1	—	1	—	—
2 Abuse of alcohol	2	1	3	1	—	2	—
3 Abuse of drugs							
(a) Personal abuse	8	1	9	—	2	4	3
(b) Offences under the Misuse of Drugs Act 1971, not relating to personal abuse	1	—	1	—	—	—	1
4 Non bona fide prescribing or supplying to others of drugs of addiction	—	2	2	—	1	1	—
5 Abuse of professional position by forming a personal relationship of an emotional or sexual nature with a patient	—	3	3	—	—	—	3
6 Dishonesty	4	1	5	—	1	1	3
7 Indecency							
(a) Offences involving abuse of professional position	3	—	3	—	—	—	3
(b) Offences committed in other than a professional context	1	—	1	—	—	—	1
8 Other charges	—	1	1	1	—	—	—
Total:	19	10	29	2	5	8	14†

† The 14 cases in which "other action" was taken by the Disciplinary Committee comprised one case of conviction in which the practitioner was admonished; eight cases of conviction in which judgment had earlier been postponed and the cases were then concluded following the receipt of satisfactory information about the doctor's conduct in the interval; one case of conviction in which the doctor's registration had earlier been suspended but no further order was made when the case was reviewed; three cases of conduct in which the practitioners were admonished after being found guilty of serious professional misconduct, and one case of conduct in which the practitioner was found not guilty of serious professional misconduct.

Other matters

The Council also received during the year 896 letters from members of the public or the profession relating to matters of professional conduct. All these letters were, with minor exceptions, considered by the President who sanctioned the replies which were subsequently sent. The letters received included requests by doctors for advice, or complaints against doctors by members of the public or by other doctors.

An example in the former category was a letter from a radiologist who sought advice on the question whether he should X-ray a patient at the request of an osteopath. The radiologist was advised that while it would be preferable for a patient to be referred by his own general practitioner for X-ray, it would nevertheless be open to the radiologist to exercise his own judgment as to whether it would be in the interests of the patient to comply with such a request by an osteopath or similar person of whose ability he had personal knowledge.

The Council has also received from members of the public or from solicitors acting on their behalf a number of complaints where it was alleged that a doctor had failed after repeated requests to provide a report on a patient required for medico-legal purposes. If a doctor contracts to examine a patient for the purpose of providing such a report, the doctor has a duty to complete that report expeditiously. Further, as stated in a booklet entitled "Medical Evidence in Courts of Law" published by the British Medical Association in 1965, "where evidence of fact is concerned . . . a practitioner has a duty to assist his patient even if he does not agree with the patient's allegation". The same booklet offers useful advice on how best to obtain either medical evidence of fact or expert medical evidence and offers suggestions for overcoming difficulties when they arise.

Pamphlet on "Professional Conduct and Discipline"

The blue pamphlet, as it is usually known, was first published by the Council in 1963 under the title "Functions, Procedure and Disciplinary Jurisdiction of the Council", when it superseded earlier and briefer Notices dealing with professional misconduct. Successive editions have sought to bring up to date the guidance which the Council felt it was able to give to the profession on matters of professional conduct, having regard to its disciplinary function under the Medical Acts. A substantial revision of this

guidance was undertaken during 1976 and 1977 by a Special Committee of the Council who obtained valuable assistance from the British Medical Association and the Medical Defence Societies. Finally, in May of last year, the text of the revised pamphlet was approved by the Council, and a copy of the pamphlet was sent last August to every doctor with a registered address in the United Kingdom. Following suggestions made in the Merrison Report the pamphlet gives extended advice on three areas of professional conduct, namely personal relationships between doctors and patients, professional confidence, and various circumstances in which questions of advertising most commonly arise.

HAVE **YOU** CHANGED YOUR ADDRESS?

If your registered address becomes ineffective, tiresome consequences may ensue. Please therefore in your own interests keep the Registrar informed of any change of address, and check that your new address has been correctly registered. If you receive no confirmation of this, please write to the Council's office at 44, Hallam Street, London, W1N 6AE. This report is being sent to practitioners at the addresses shown in their entries in the Register on 14th April, 1978. 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.

EUROPEAN ECONOMIC COMMUNITY: THE FIRST YEAR'S EXPERIENCE OF FREE MOVEMENT FOR DOCTORS

by M. R. Draper
Registrar

In the Council's Annual Report for 1976 I wrote that "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 two EEC Medical Directives providing for free movement were supposed to be given effect in each Member State by December 19, 1976. But in the United Kingdom the Order in Council which was necessary to alter the law so as to permit and indeed require the GMC to register doctors who had qualified in the Continental Member States was not made until May 11, 1977, and took effect on June 10.

The full title of this Order is "The Medical Qualifications (EEC Recognition) Order 1977". It amended the Medical Acts so as to require the Registrar to register any person who, being a national of any Member State of the EEC, holds a medical qualification granted in a Member State (which need not be the same State). A person entitled to registration under these provisions must also show "on or after registration" that "he has the necessary knowledge of English, that is the knowledge which in the interests of himself and his patients is necessary to the practice of medicine in the United Kingdom". In practice it means that a doctor may be registered for six months, but thereafter his registration will normally lapse unless he passes a language test or falls within one of the categories of exemption defined by the Council. This provision has provoked much criticism of the United Kingdom among the Continental Member States, who have asked the EEC's Commission to examine this aspect of the Order.

By February, 1978, the Directives had been implemented in every Member State except Italy where legislation has been delayed. Although some practical problems remain to be solved, it is thus now possible for doctors to establish themselves in

practice in all but one of the Member States, but it is not yet fully clear how many doctors are availing themselves of this opportunity. The EEC Commission is collecting statistics of the number of migrating doctors, and until these are published the number of doctors leaving the United Kingdom to practise elsewhere in the EEC will not be accurately known. The Council has no comprehensive information because doctors seeking registration in some of the other Member States do not require documents from the GMC to support their applications.

As far as incoming doctors are concerned, between June 10, 1977 (when the Order became effective) and January 31, 1978, 92 doctors who were nationals of a Member State and who had qualified in a Member State other than the United Kingdom or Ireland had been granted full registration. Some of these were United Kingdom nationals and a considerable proportion had been working in this country for some time. It may be interesting to note for comparison that during the *whole* of 1977 full registration was granted to 2882 doctors who had qualified in the United Kingdom, to 336 doctors who had qualified in the Irish Republic, and to 2800 doctors who had qualified overseas outside the EEC.

In some of the other Member States recognition as a specialist confers defined privileges, such as higher rates of payment. The Order in Council confirmed the GMC as the authority competent to issue certificates of specialist training and associated documents required by United Kingdom qualified doctors seeking to practise as specialists in another Member State. Such doctors should write to the Council's office for information about these certificates. The standard of attainment required for a specialist certificate is defined by the Second Medical Directive. The length of training required varies between the different specialties but in some cases is shorter than that required in the United Kingdom for accreditation by a Joint Higher Training Committee. The Council keeps, separately from the Register, a specialist list of persons holding EEC specialist qualifications.

Doctors who are making short visits to another Member State and who do not wish to establish themselves there, may provide services on a temporary basis (prestation). The Order made arrangements for doctors from other Member States to do this in the United Kingdom, and requires me to keep a "list of visiting EEC practitioners" showing their names and qualifications, and

the periods for which their registration as visiting EEC practitioners is effective. By January 31, 1978, only one such application had been received.

Reference was made in the last Annual Report to the Advisory Committee on Medical Training which has been established within the EEC with a view to setting up some system of quality control over medical education. Although this Committee has met during 1977 it is likely to be some years before it is in a position effectively to influence the development of undergraduate or specialist medical education in Member States. It can, of course, have no effect over the quality of the medical education received by doctors who qualified before 1976 — and it is these doctors who are at present seeking registration here. The only system of "quality control" existing in respect of these doctors is the requirement that they must either produce a certificate to show that the standard of their qualification complies with the Second Medical Directive — this is expressed in fairly general terms, and experience suggests that such certificates are not difficult to obtain — or that the doctor has been lawfully engaged in actual medical practice for at least three consecutive years during the last five. The philosophy of the EEC is that each Member State accepts the existing arrangements of the other subject to eventual harmonisation in the future. It is on this basis that the Directives were framed and the laws of this country have been modified to take account of them.

FINANCE

The following summary shows the main items of the Council's income and expenditure for 1977:

Income		*Expenditure*	
Annual retention fees	£634,716	Education	£ 32,627
Fees received on provisional or full registration:		Professional conduct and discipline	£110,659
British and Irish doctors	£ 81,780	Registration of British and Irish doctors	£ 44,398
Overseas doctors	£ 96,280	Maintenance of Register	£ 78,692
Fees received for EEC certificates	£ 9,201	Registration of overseas doctors	£185,694
Fees received for temporary registration of overseas doctors	£177,380	TRAB tests	£ 91,738
Fees received from candidates for the TRAB tests	£ 84,955	Collection of annual retention fees	£125,053
Sales of Medical Register and Fortnightly Lists	£ 41,742	Publication of Medical Register and Fortnightly Lists	£ 38,358
Other sources including net investment income	£ 51,848	EEC activities	£ 26,330
		General administration	£250,779
		Appropriated to staff superannuation fund in respect of renewed liability for past service arising from inflation	£ 22,766
Total	£1,177,902	*Total*	£1,007,094

In the foregoing table the sum shown as expenditure on general administration includes all expenditure which it would be unrealistic or impracticable to apportion accurately amongst the other headings — for example, meetings of the Council, cost of staff employed on common services, cost of general publications of the Council, and charges for legal, actuarial or financial advice. The sum shown under general administration is smaller than the corresponding sum shown for this in the previous Annual Report (£313,070) because the greater part of the cost of the Council's premises, which in previous years had been included under general administration, has for 1977 been distributed among the various activities, and this has correspondingly increased their cost as shown in the table.

The Council has sought to limit the burden falling upon the profession through the annual retention fee, and with this in mind increased substantially the fees for taking the TRAB tests with effect from September 1, 1977. In consequence nearly the whole of the expenditure of the TRAB tests (£91,738) was covered by the fees paid by candidates for the TRAB tests, and only £6,783 required to be met from the fees payable for temporary registration.

The Council also increased the fees for temporary registration with effect from July 1. As a result fees received during 1977 from the registration (provisional, temporary or full) of overseas-qualified doctors and from candidates for the TRAB tests brought in £358,615, while expenditure on such registrations and on conducting the TRAB tests cost £277,432. The difference between these two sums represents the contribution made by overseas-qualified doctors to the general expenditure of the Council: a similar contribution comes from the fees paid by British and Irish qualified doctors for provisional or full registration.

There was a surplus of income over expenditure in 1977 which was transferred to the General Reserve. This stood at £508,270 at the end of the year — that is to say at approximately half the Council's current annual expenditure. Expenditure in future years will be increased by inflation, by the various changes and new activities recommended in the Merrison Report, and by the need for new premises when existing leases expire in 1983 and 1994. The Council therefore thought it prudent to increase the fees payable on provisional and full registration with effect from January 1, 1978, and an increase in the annual retention fee may be necessary in 1979.

Copies of the Council's Accounts for 1977 may be obtained from the Registrar.

During 1977, the Council lost, through retirement, Sir John Brotherston and Professor William Jessop.

Sir John Brotherston, MD, FRCP, DPH, served on the Council for 21 years, first as the representative of the University of Edinburgh from 1956 until 1964, and then as a member appointed by the Crown to represent Scotland from 1964 onwards. He served on 17 Committees of the Council, and was twice acting Chairman of the Executive Committee, and twice acting President. He was also the first Chairman of the Education Committee, holding the post from 1970 until 1975. He is succeeded by Professor John Reid, CB, TD, MD, previously a member appointed by the Crown to represent England and Wales. Professor Reid is replaced by Dr. Gillian Ford, FFCM, Deputy Chief Medical Officer.

Professor William Jessop represented the University of Dublin from 1961 onwards and served on many Committees, including the Executive Committee, the Disciplinary Committee, the Penal Cases Committee and the Overseas Committee. He is succeeded by Professor James Stevenson McCormick, FRCP Irel, Dean and Professor of Social Medicine of the University of Dublin.

The year saw the death of six former members:

The Rt. Hon. Lord Cohen of Birkenhead, CH, MD, served on the Council from 1945 to 1973 as a member appointed by the Crown for England and Wales, and was for 12 years, until his retirement, President of the Council. Lord Cohen was a President of the greatest distinction and his services to the Council were of inestimable value. A tribute to his services was included in the Annual Report for 1973 when Lord Cohen retired.

Dr. John Gibb McCrie represented the University of Sheffield for 25 years until his retirement in 1972. He was Treasurer from 1965 to 1972, and Senior Treasurer at the time he retired.

Dr. Eric Arthur Gerrard was an elected member for England and Wales for 5 years from 1966 to 1971.

Dr. Thomas Ferguson represented the University of Glasgow from 1958 to 1961.

The Rt. Hon. Lord Moran of Manton, MC, MD, represented the Royal College of Physicians of London from 1944 until 1950.

Sir Arthur Peregrine Thomson represented the University of Birmingham for 14 years until his retirement in 1965.

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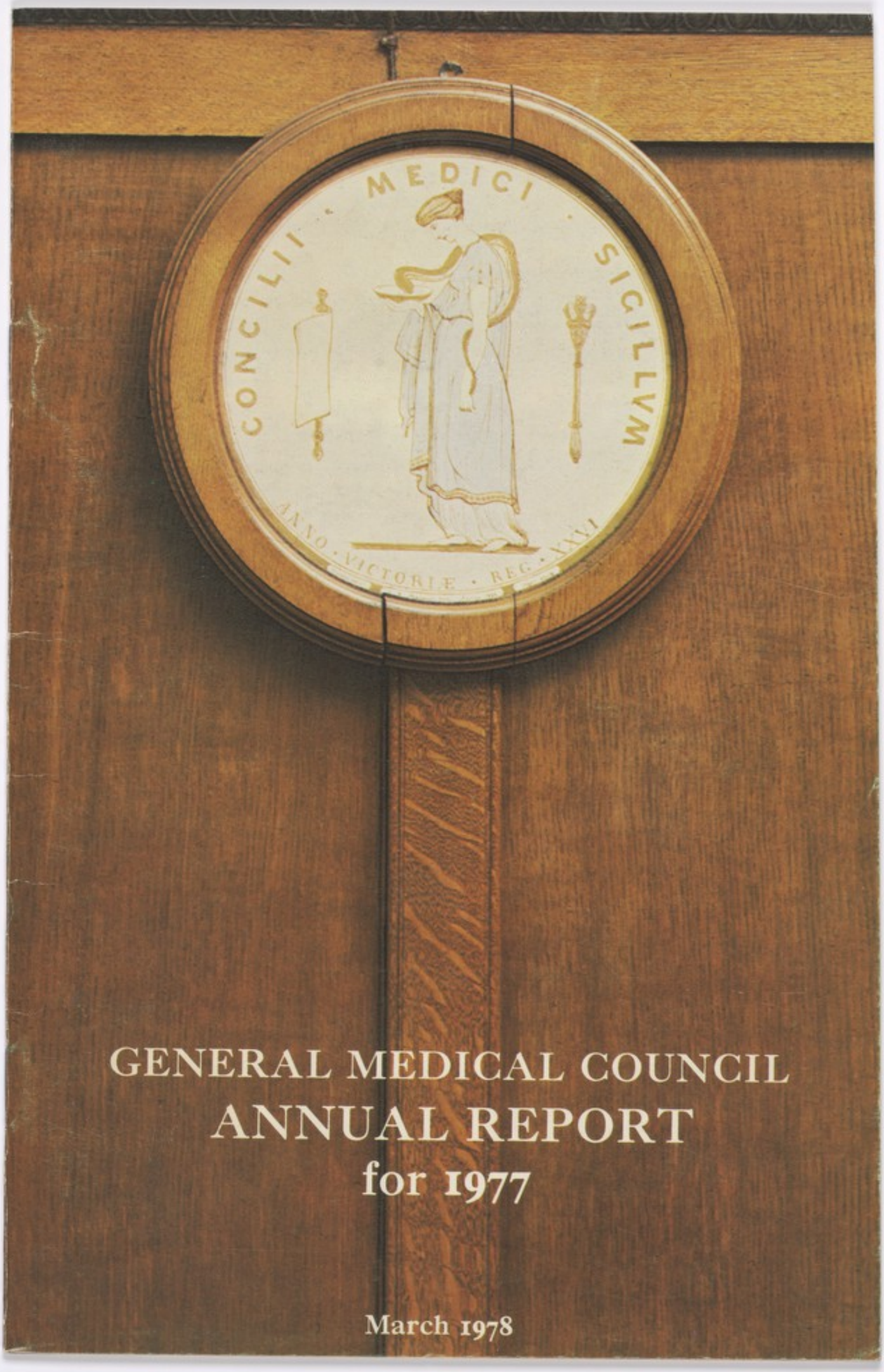

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1977

March 1978