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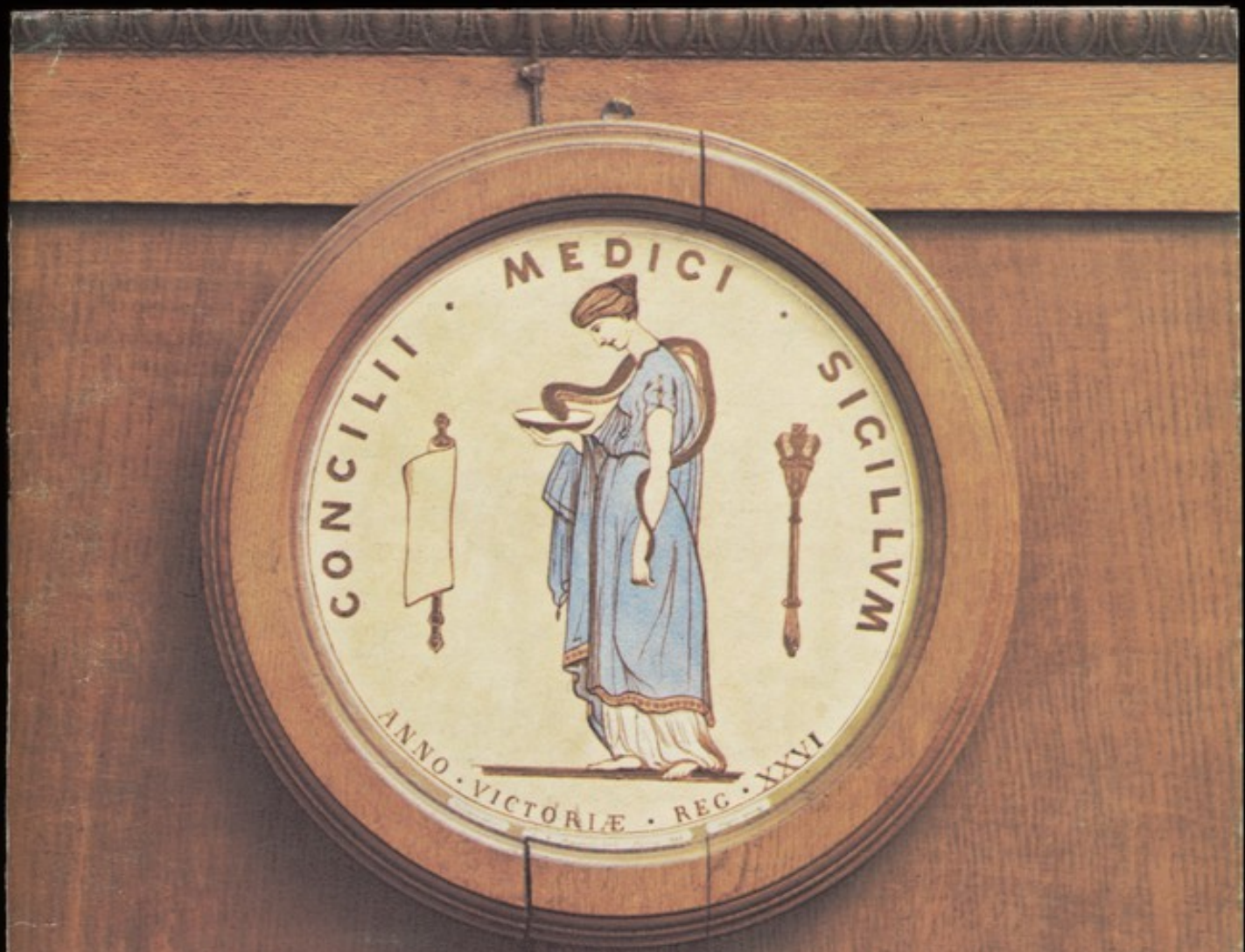

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1978

March 1979

THE GENERAL MEDICAL COUNCIL

March 1979

President

The Rt. Hon. LORD RICHARDSON MVO FRCP Lond

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Katharine Farquharson Bradley MB John Fry OBE FRCGP Sir Ronald George Gibson CBE FRCGP Michael Thomas O'Donnell MB Stanley Clifford Simmons FRCOG Paul Richard Jarvis Vickers FRCS Eng Rowland James Williams FRCS Eng John Winter MD William Jeffrey Cullen Scott VRD MRCGP Alastair William Wright FRCP Edin Thomas Horner MD	Elected by	The registered medical practitioners resident in England and Wales, Scotland and Ireland

allam Street, London, W1N 6AE
e: 01-580 7642

THE MEDICAL ACT 1978

by Lord Richardson, MVO, MD, FRCP,
President of the General Medical Council

When I wrote in the Report last year, the Medical Bill was in the process of passing through Parliament and, in so doing, undergoing considerable changes. I felt, therefore, I should not speculate about its ultimate content but committed myself to report in some detail upon it this year. The Royal Assent was given to the Act of 1978 on May 5, and I am now able to fulfil my undertaking and to give an account of the forthcoming changes and their expected timing.

The Order establishing the constitution and the Succession Day has been made, and the old Council will cease to exist and the new one be born on September 27, 1979. Before discussing the results of this great change in composition and function I wish first to mention matters which have already taken place.

The Act of 1978 allowed certain provisions to come into force in advance of the Succession Day. The first required the Council, from December 1, 1978, to satisfy itself about the linguistic competence of those from overseas who were applying for full or provisional registration. The second came into force on February 15 1979 when limited registration for overseas doctors replaced temporary registration. These changes are discussed in more detail on pages 11–13 of this Report, but in essence, after the first year of limited registration, an overseas doctor will be able to pursue, under supervision, a series of hospital appointments within the National Health Service without re-registering on change of post, as had previously been the case with temporary registration. Further, it will be possible for many of those with limited registration eventually to become fully registered without requalifying here provided the General Medical Council can be satisfied that the individual's training and attainments justify the granting of full registration.

Whilst these matters were being introduced, preparations were, and are, going forward directed towards the setting up of the new Council.

An electoral scheme has been prepared and, following wide discussion by professional bodies, has been agreed by the General

Medical Council and subsequently by the Privy Council. The proposed dates in relation to the election and the work of the new Council will be found on pages 4 and 5. The arrangements for the actual election have been made in conjunction with the Electoral Reform Society, and the method of election will be that recommended by Sir Alec Merrison's Committee, namely, by single transferable vote.

After a note about the composition of the new Council, on page 4, is a table of expected dates and a few notes on the election itself, and following this, information about the new relationship with the Republic of Ireland. I cannot let this opportunity pass without saying how greatly the present Council regrets that a changing world has resulted in the breaking of the old ties between itself and the Irish Republic. The members from educational bodies in Eire have contributed much to the work of the Council and to the enjoyment of those sitting on it and working for it. There is, however, some comfort in that it should be possible, through co-option on to the respective Education Committees, for a liaison to exist between the new Council and the Medical Council of Ireland.

There have had to be some changes in the building at No. 44 Hallam Street itself so that a Council of 95 members could meet in the present Council Chamber, and to meet the other needs resulting from a more than doubling of the membership. These changes have been completed and thus it is expected that the new Council will be adequately accommodated when it meets on September 27, 1979.

The new Council will, as soon as it is formed, have to take various decisions concerning its new responsibilities in addition to carrying on the day to day business of the Council, which is both voluminous and detailed, and cannot be interrupted. It will be necessary, therefore, for the Council at its first meeting to elect a President, Committees and their Chairmen, to carry on with the ordinary work and to prepare for the Council's meeting early in November when decisions will need to be made on a number of important matters. The Education Committee will have to determine what is to be regarded as sufficiency in the educational sense at the point of qualification, and subsequently at the time of full registration. Later it will be necessary for it to consider its responsibilities in the postgraduate field of medical education and how it can best promote high standards throughout the whole

educational process. Discussion of the educational changes will be found on pages 7–9.

Changes in the rules for the disciplinary functions of the Council will have to be made, to deal with the new power of immediate suspension by the Preliminary Proceedings Committee and of conditional registration by the Professional Conduct Committee and later by the Health Committee. These changes are summarised on pages 10–11. The new Council will also be required to give advice on standards of professional conduct and on medical ethics, matters which will need careful thought and will be hardly susceptible to rapid solution.

The new Council will undoubtedly wish to set up the new Health Committee referred to on page 10 as soon as it is possible for agreement to be reached by those concerned, and to this end the present Council has already put out a consultative document so that it can hand to the new Council information about ideas and points of view on which it can work when it comes into office.

The necessity for these preparations requires no emphasis, but two points should be stressed, the first that the present Council has done, and will do, nothing to pre-empt the rights of the future one, and secondly, in preparing such drafts as it has done the Council has followed closely the advice of the Merrison Committee whose report received such wide acceptance.

The changes which will begin to be effected next autumn are the most sweeping that have occurred at any one time in the 121 years of the Council's existence. It is unquestionably right that they should be carried through by a body with a majority elected by general suffrage within the profession. The size of the new Council will clearly carry with it problems, not the least of which will be the promotion of a sense of involvement with the Council which will be so important to its successful working. Even with the present Council's membership of 46 all cannot be equally engaged in Council activities. Nevertheless, it has long seemed to those on the Council that it is easy to form friendships between those serving on it, largely perhaps because of the work itself, which is never easy and is often taxing, thus requiring tolerance and attention to other people's points of view. It is profoundly to be hoped that the size of the new Council will not diminish this sense of involvement and fellowship, and if the importance of these things is recognised I do not believe that it will.

TIMING OF THE CHANGES TO BE MADE UNDER THE MEDICAL ACT 1978

The different provisions of the Medical Act 1978 will come into force on different days appointed by Order in Council. The dates or expected dates for the principal provisions to come into force are set out below:

December 1, 1978	Proficiency in English was required for full or provisional registration of overseas qualified doctors
February 15, 1979	The temporary registration of overseas qualified doctors was superseded by limited registration. Some other provisions in the Act relating to the registration of overseas qualified doctors also came into force on that day
September 27, 1979	The Succession Day on which the reconstituted Council will take office

After the succession day the educational provisions of the new Act, described on pages 7 to 9 of this report, will come into force as soon as the Education Committee of the new Council is ready to determine new standards for qualifying. Later, probably in 1980, the new provisions for the full registration of overseas qualified doctors described on pages 11 to 13 of this report will come into effect. Also in 1980 or later the new Health Committee will be established – see pages 10 to 11 of this report.

COMPOSITION OF THE NEW COUNCIL

The composition of the new Council was determined by an Order made by the Privy Council on February 6, 1979. Under the Order the new Council will consist of 50 members elected by the profession, 34 members appointed by the Colleges or Faculties, and 10 or 11 members nominated by the Privy Council.

Of the elected members 39 will be elected by doctors resident in England, the Channel Islands, or the Isle of Man, three by doctors resident in Wales, six by doctors resident in Scotland and two by doctors resident in Northern Ireland. The arrangements for the election are described on page 5 below.

22 members will be appointed by the Universities with Medical Schools (including for the first time the Universities of Nottingham, Southampton and Leicester). The Universities will appoint one member each except London which will appoint three. The other 12 members will be appointed by the Royal Colleges of Physicians and Surgeons in England and Scotland, the Royal College of Obstetricians and Gynaecologists, and the Royal Colleges of General Practitioners, Pathologists, Psychiatrists and Radiologists. The Society of Apothecaries, the Faculty of Anaesthetists and the Faculty of Community Medicine will also each appoint one member.

A majority of the members nominated by the Privy Council are to be lay members: it is expected that six lay members will be appointed. The Privy Council is also expected to nominate the Chief Medical Officers for England, for Scotland, for Wales and for Northern Ireland, or their deputies. If no overseas qualified doctor has been elected or appointed to the Council, the Privy Council will also nominate one such member.

No-one who has reached the age of 70 is eligible to become or to remain a member of the Council.

ARRANGEMENTS FOR THE ELECTION OF ELECTED MEMBERS OF THE NEW COUNCIL

The election of the elected members of the new Council will be carried out between April and August, 1979, as follows:

May 3	Last day for the return of nomination papers
June 8	Date by reference to which the electoral roll is to be prepared
July 4	Despatch of voting papers
August 1	Last day for the return of voting papers
August 20	Announcement of results of the election

As recommended by the Merrison Report the single transferable vote will be used in the election. Instructions on how to vote by this method will be sent to each doctor entitled to vote. The electorate will consist of fully and provisionally registered doctors whose registered addresses are in the United Kingdom, the Channel Islands or the Isle of Man, and also doctors holding limited or temporary registration who have held one of those forms of registration for periods amounting to not less than three years during the four years preceding the election.

NEW ARRANGEMENTS WITH THE REPUBLIC OF IRELAND

When the General Medical Council was first established in 1858 what is now the Republic of Ireland was part of the United Kingdom. Members from Southern Ireland sat on the General Medical Council on the same basis as members from other parts of the United Kingdom, and doctors qualifying in Southern Ireland were registered by the Council on the same basis as doctors who qualified in England or Scotland. These arrangements survived the partition of Ireland in 1921. Members representing the Universities and Colleges in the Irish Republic continued to sit on the Council, and one member was elected to the Council by doctors resident in the whole of Ireland. The General Medical Council continued to exercise the same powers in relation to the standards of medical education in the Irish Republic as it did in relation to the United Kingdom.

The Medical Act 1978 provides for these arrangements to change. After a transitional period of about seven years doctors qualifying in the Irish Republic will be eligible for registration in the United Kingdom only on the basis of common membership of the EEC, and vice versa. The practical difference is that eligibility for registration by virtue of qualifications granted in each country will then be available only to persons who are nationals of a Member State, although the registration of persons now registered or becoming registered during the transitional period will be preserved. After the Succession Day (September 27, 1979) the General Medical Council will no longer include members from the Irish Republic, and will cease to exercise any functions in relation to the standards of medical education in the Irish Republic.

The Medical Act 1978 when fully in force will make substantial changes in the Council's functions in relation to medical education. The more important of these are summarised below.

The Education Committee

Although the present Council works through an Education Committee, its legal powers in relation to medical education are vested in the Council. After the reconstitution of the Council these powers will be transferred to and exercised by the Council's Education Committee in the same way as, since 1951, the disciplinary functions of the Council have been discharged by its Disciplinary Committee. The new Council will elect the Education Committee which under the Act must have on it a majority of members appointed to the Council by the Universities and Royal Colleges.

Functions of the Education Committee

Whereas hitherto the Council's educational functions have in law been largely restricted to maintaining minimum standards of undergraduate medical education, the Education Committee of the new Council is given "the general function of promoting high standards of medical education and co-ordinating all stages of medical education". Thus for the first time the body responsible for maintaining the standards of primary qualifications will also be responsible for maintaining the standard of the pre-registration year and concerned with subsequent stages of medical education. This arrangement fulfils the recommendations made both in the Todd and the Merrison Reports.

The standard required for qualification

Hitherto the standard required for qualification (that is to say for obtaining degrees of MB BS or diplomas such as MRCS LRCP) has been prescribed by the Medical Acts. The Medical Act of 1886, which stood unchanged until 1978, prescribed that the standard of qualification should be "such as sufficiently to guarantee the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery". This standard, besides being rigid, had become progressively less realistic. In future it will be the function of the Education Committee to

"determine the extent of the knowledge and skill which is to be required for the granting of primary United Kingdom qualifications (e.g. MB BS and MRCS LRCP) and secure that the instruction given in Universities in the United Kingdom to persons studying for such qualifications is sufficient to equip them with knowledge and skill of that extent". It will also be the function of the Committee to determine the standard of proficiency which is to be required from candidates at qualifying examinations and secure the maintenance of that standard. The Education Committee's determinations on these matters are to be embodied in recommendations directed to the Universities and other bodies concerned with medical education. The Education Committee will inherit the present Council's powers to visit and inspect medical schools and examinations and, if dissatisfied with the standards in any of them, to make representations to the Privy Council which in such circumstances has power to declare unregistrable the qualifications of a particular University or other Licensing Body.

Standards for the pre-registration year

Hitherto the only statutory function of the Council in relation to the pre-registration year has been to make Regulations prescribing the total length of the period (12 months), the periods to be spent in medicine and surgery respectively, and the form of the Certificate of Experience which the doctor must obtain from his medical school at the end of the year in order to obtain full registration. The Medical Act gives to the Education Committee of the new Council a new function to determine patterns of experience suitable for giving to young graduates general clinical training during this period. The Committee is also authorised to appoint persons to visit hospitals which have been approved for pre-registration service, and given power to notify a University if the Committee thinks that an approved hospital does not provide the required experience, or that a combination of posts accepted by the University from its graduates during the pre-registration year is unsuitable. If this happens, the Act says that the University is to have regard to the Council's opinion. But the Act leaves with the Universities the primary responsibility for supervising the pre-registration year and increases their discretion to withhold a Certificate of Experience from a graduate who has not obtained the requisite experience.

Recommendations on Medical Education

The determinations made by the Education Committee as to the standard of the undergraduate curriculum and the patterns of experience to be required during the pre-registration year are to be embodied in Recommendations to the Universities and other Bodies concerned with medical education. This arrangement gives statutory recognition to the practice long followed by the present Council in publishing its views on the undergraduate curriculum in the form of Recommendations. The last such Recommendations were issued by the Council in 1967.

During 1978 the Council, through its Education Committee, reviewed the 1967 Recommendations and prepared a draft of new Recommendations intended to fulfil the requirements of the new Act. In preparing these Recommendations the Council has taken into account the developments in medical education since 1967, including extensive changes in the curricula introduced by many schools, views which have been voiced at the educational conferences which the Council has arranged in recent years, the results of the survey of basic medical education and the present arrangements made by the Joint Higher Training Committees for post-graduate training in the various specialties including general practice. The draft of new Recommendations deals not only with the undergraduate curriculum but also covers the pre-registration year and embodies material on this which the Council included in the Code of Good Practice issued in 1973. The present Council has sent the draft to Universities, Medical Schools and other Bodies interested in medical education for comments so that the Education Committee of the new Council can at its first meeting consider the draft and the views of the educational Bodies on it. As soon as the Education Committee of the new Council is ready to adopt new Recommendations, the way will be open to implement the sections of the Medical Act 1978 relating to medical education.

A role for the GMC in relation to the sick doctor

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

The foregoing paragraph, quoted from the Merrison Report, was welcomed by the GMC and indeed reflected the Council's own evidence to the Merrison Committee. The Medical Act 1978 has provided for the establishment by the Council of a Health Committee to consider cases "where the fitness to practise of a registered person is seriously impaired by reason of his physical or mental condition". Before the Health Committee can be established and begin to work the new Council will have to make Rules for its procedure after consulting with bodies representing medical practitioners and the Rules will require the approval of the Privy Council. It will therefore be some considerable time – perhaps a year – after the reconstitution of the Council before the Health Committee can begin to function.

The Medical Act 1978 also made minor changes in the existing disciplinary machinery of the Council. The main ones are to change the name of the Disciplinary Committee to the Professional Conduct Committee, and to give it a new power to make a doctor's registration conditional on his compliance with such requirements as the Committee may think fit to impose for the protection of members of the public or in his own interest. In addition the Preliminary Proceedings Committee, which will replace the present Penal Cases Committee, is to have a new power to order interim suspension or conditional registration for a period not exceeding two months if it considers this necessary in any case which is referred by that Committee either to the Professional Conduct Committee or to the Health Committee. These changes, like the establishment of the Health Committee, will not come into force until some months after the new Council has met. The reason for this is that the new Council must first, after consulting

medical bodies, make rules for the new Committees, and these rules must then be approved by the Privy Council. Until all this has been done the new Council, like the present Council, will have to work through a Disciplinary Committee and a Penal Cases Committee.

The Act also breaks new ground by saying that "the powers of the Council should include that of providing, in such manner as the Council think fit, advice for members of the medical profession on standards of professional conduct or on medical ethics". This provision gives effect to a recommendation in the Merrison Report that the Council should assume an active role in the establishment of high standards of professional conduct to complement its present disciplinary function. It will be for the reconstituted Council to consider how these new powers should best be exercised. Some of the issues which will arise are discussed in the article by Dr. O'Donnell on pages 17 to 18 of this report.

NEW ARRANGEMENTS FOR THE REGISTRATION OF OVERSEAS QUALIFIED DOCTORS

The Merrison Report devoted a whole Chapter to the arrangements for the registration of overseas qualified doctors. Thirteen of the 32 sections of the Medical Act 1978 and a whole Schedule relate to the same matter. The arrangements operating under the previous Medical Acts had been found unsatisfactory in several ways. The Medical Act 1978 has provided for a number of improvements which will come into operation at different times.

Knowledge of English

Since June, 1975, the Council has required doctors applying for temporary registration to demonstrate, usually by passing the TRAB tests, that they are proficient in English, but the Council has had no power to require this when granting full or provisional registration to overseas qualified doctors. The Medical Act 1978 has authorised the Council, with effect from December 1, 1978, to require all overseas qualified doctors applying for full or provisional registration to demonstrate their proficiency in English.

New arrangements for full registration

The Medical Acts in force since 1886 have provided for the granting of full registration to overseas qualified doctors on the basis of

reciprocity with certain other countries. This became progressively inconvenient in two different ways. First it was not possible to extend the privileges of registration to doctors, however well qualified, who came from countries not willing to establish reciprocal arrangements with the United Kingdom: this excluded doctors from the whole of the United States and from many of the Provinces of Canada. On the other hand the existence of reciprocal arrangements could give rise to difficulties if the Council thought it necessary to withhold or to withdraw recognition from qualifications granted in countries with which such arrangements existed. Under the Medical Act 1978 the system of reciprocity will be discontinued and it will be open to the Council at its discretion to recognise for full registration qualifications granted in any country if the Council is satisfied that such qualifications attest the possession of knowledge and skill and the standard of proficiency required to obtain primary medical qualifications in this country (for example MB BS or MRCS LRCP). Because the acceptability of the standard of these qualifications is related to the standards which the Education Committee of the new Council will have to determine in relation to British qualifications, this change cannot take place until after the new Council has come into being and its Education Committee has formally established such standards.

The Medical Act 1978 also provided for the former system of temporary registration to be superseded by a new and more flexible system of limited registration. The system of limited registration will ease the lot of the overseas qualified doctors in this country since limited registration may be granted at the Council's discretion for a whole range of employment and not only for a particular post. Limited registration will be available only for employment under the supervision of a fully registered practitioner. Subject to this requirement, and to any further restrictions which the Council thinks fit to impose in individual cases having regard to the knowledge, skill and experience of the individual, it can be granted for several years at a time for any supervised employment in the hospital service of the National Health Service. There is an overall time limit of five years for which an individual may hold limited registration, but this time limit will not apply to doctors who have held temporary registration and apply for limited registration within a specified period.

The Act also enables the Council at its discretion to grant full

registration, without the necessity of requalification by examination, to persons who have held limited registration if the Council think fit to give them full registration having regard to the knowledge and skill shown and the experience acquired by the individual doctor. It is for the Council to decide what criteria will be applied to the granting of full registration under these provisions, and the Council has stated that a high standard of practice will be required. Normally doctors must show that they have been in clinical practice for at least four years and, in addition to having served an acceptable internship, have been employed in substantive posts for two years at the grade of registrar or equivalent or above. At least one of these years as a registrar must have been served in hospitals in the United Kingdom.

In view of the extent of the discretion in these matters given to the Council, the Medical Act has provided for the establishment of the Review Board for Overseas Qualified Practitioners to whom doctors may apply if registration has been withheld from them in certain circumstances. The grounds on which application may be made include the withholding of registration on grounds of character, refusal to renew limited registration or to grant it to a doctor who has held temporary registration and applies for limited registration within the specified period, erasure from the Limited Register on the ground that the doctor's performance while holding limited registration shows that he does not possess the appropriate knowledge and skill, and refusal of full registration after limited registration where a doctor has held limited registration for not less than three years and six months. The Review Board consists of a Chairman and Deputy Chairman appointed on the recommendation of the Postgraduate Councils, at least one overseas qualified doctor, and members of the Council who were not involved in taking the decisions under appeal. The Act makes no provision for doctors applying to the Review Board to pay the costs of the application: accordingly the whole of the cost of the activities of the Review Board will fall upon the medical profession through the annual retention fee.

THE COUNCIL AND THE PRE-REGISTRATION YEAR

by Sir John Walton, TD, MD
Chairman of the Education Committee

Introduction

The Medical Act of 1950 laid down that with effect from January 1, 1953, after graduation and provisional registration all newly qualified doctors in the United Kingdom should be required to undertake a period of pre-registration service and that a certificate of satisfactory completion of such service should be provided by a University or Licensing Body before a doctor could be fully registered with the Council. Regulations made by the Council in 1951 fixed the length of this period as 12 months, and prescribed that six months should be spent in medicine and six months in surgery, except that, as contemplated in the Medical Act, up to six months could be spent in midwifery or up to six months in a Health Centre in place of either medicine or surgery. Subsequently the Council's Recommendations of 1967 expressed concern at the limited educational value of the arrangements then operating, and in March, 1972, the Council held a conference upon this topic. Arising out of the proceedings of that conference the Council issued in 1973 a Code of Good Practice for Universities and Medical Schools, making recommendations about such matters as the maintenance of standards of the posts approved for pre-registration service, the guidance, placing and supervision of graduates, and medical school administration.

Implementation of the Code of Good Practice

In 1976 the Council issued a questionnaire to medical schools to discover to what extent the Code of Good Practice had been implemented. Analysis of the responses revealed that although the principles laid down were being widely adopted, there were still a number of deficiences. In view of these the Council decided to hold a further conference in February, 1978, in order to discuss the results of the Council's survey and also to determine whether, in the light of changes in medical practice and in vocational training in various specialties which had taken place in the last few years, there should be any change in the regulations governing the year.

The conference proved useful. It was generally agreed that the principal objective of the pre-registration year was one of learning

by service rather than through formal programmes of post-graduate training. It was further agreed that the quality of experience offered by such posts had been improved considerably through increasing implementation of the Code of Good Practice, though the situation was by no means perfect and some appointments remained less satisfactory than others. Since it had proved impossible in all cases to achieve the recommendation of the Code that each hospital department containing pre-registration posts should include at least one senior registrar or registrar, readily available, to provide cover at all times, it was agreed to amend the Code of Good Practice to indicate that under certain circumstances direct and immediate supervision by a senior house officer in the same branch of medicine might be acceptable, provided that a consultant or registrar were always available for consultation.

The Council also agreed that the responsibility for supervising and certifying the pre-registration experience of diplomates of the non-University licensing bodies would in future be undertaken by the appropriate officer of the medical school where the doctor had studied, or, in the case of doctors from overseas schools, of the University in whose region the doctor concerned held his pre-registration appointments.

Changes in the Regulations

At the conference in February, 1978, views were widely expressed that the regulations covering the content of the pre-registration year should be modified to allow greater flexibility between the periods to be spent in medicine and in surgery. Such flexibility was now felt to be appropriate in view of the fact that no doctor will in future be able to become a principal in general practice without undergoing three years of vocational training. Further many pre-registration posts at present classified as being in general medicine or surgery expose the holder to highly specialised forms of practice within these major disciplines while, on the other hand, many specialised posts in, for instance, urology or cardiology, to quote but two examples, can afford good general surgical or medical experience.

After considering the outcome of the conference the Education Committee recommended and the Council accepted that the regulations should be modified. While the overall length of the pre-registration year has not been altered, the minimum periods to be spent in medicine and in surgery have each been reduced to four

months. This will allow the provisionally registered doctor a wider choice of options. Although many graduates will continue to spend six months in medicine and six months in surgery, the new Regulations will permit four months in medicine, four months in surgery and four months in another discipline. Other permissible arrangements will include three months in medicine and three months in a medical specialty followed by three months in surgery and three months in a surgical specialty, or four months each in general medicine and surgery and two months each in a medical and surgical specialty. For the time being the Regulations also allow the option of up to six months in midwifery or in a health centre in place of either medicine or surgery.

These options however are limited by the small number of posts in midwifery and in health centres which are recognised for pre-registration service. The option of midwifery is likely eventually to disappear as a result of changes made by the Medical Act 1978. On the other hand more health centres may be approved but it is likely that the period which may be spent in a health centre will be limited to four months.

WHOSE ETHICS?

by Dr. Michael O'Donnell, MB

The new Medical Act contains a clause empowering the GMC to advise members of the medical profession on standards of professional conduct or medical ethics. (The significance of that "or" eludes me.) The clause does not extend the Council's disciplinary powers and gives the GMC no new sanctions to use against doctors who disregard its guidance. The intention is to implement the Merrison Committee's recommendation that the Council should be seen to be concerned more with good professional conduct than with serious professional misconduct.

The idea is commendable but will be difficult to implement. If I understand Merrison aright, one reason for changing the GMC's composition was to make it more representative of the profession so that when, say, it issued ethical guidance, that guidance would be, as near as administrative manoeuvre could achieve, the consensus view of the profession. The problem will lie in establishing the consensus because, in my cynical experience, those most noisily in favour of doctors receiving ethical guidance are those who would like to impose on others rigid "ethical" rules that they impose upon themselves.

The Merrison Report did not suggest the GMC should be a fount of dogma; it saw it more as a stimulator of debate and the GMC's experience of issuing guidance on undergraduate medical training without laying down rigid curricula should help it when it comes to issuing guidance on professional conduct.

Discussions we've had on the Council's committee on professional conduct have taught me there are two ways the Council could try to give guidance. The first would be to respond to the fact that most doctors seeking advice want to know what they can do rather than what they cannot. Indeed they usually want to know if something they are considering doing will get them "into trouble" with the GMC. The natural response to that sort of request is to play it safe and advise doctors not to do anything that might be questioned by any of their peers. Paradoxically their request for positive advice would have to be answered in a negative way with a series of "thou shalt not" commandments which, if obeyed by all, would cut the Council's "disciplinary"

bill but would cast the GMC in the sort of negative role that the Merrison Committee was so keen it should avoid. Said the Merrison Report: "Nor are we so naive as to believe that the GMC could ever hope to dictate rules for doctors. What we believe the GMC can and should do is to be the centre of public debate, explaining – to the public as much as the profession – advising, and, if need be, warning."

The alternative to producing a list of "safety instructions" designed to keep doctors out of trouble is to try and anticipate ethical problems likely to confront doctors and to distil a consensus of professional opinion on how doctors should cope with them, not harping on misconduct but defining what is good professional conduct. If it is to do this, the GMC itself will need guidance. Where can it look for it?

The Hippocratic Oath sounds fine but on close study yields up wholly ambiguous ethical advice. The World Medical Association's modern restatement of the oath in the Declaration of Geneva is less enigmatic than Hippocrates but is also less helpful than the practical experience accumulated by bodies like the BMA's Ethical Committee and the Royal Colleges. These bodies have recently formed joint committees to offer guidance on problems like brain death or the ethical implications of doctors taking industrial action. Medical schools, often co-operating with organisations like the London Medical Group and the Society for the Study of Medical Ethics, now stimulate more debate than they used to about ethical problems, debate which some years ago gave birth to the Journal of Medical Ethics.

Doctors hold disparate views on many of the subjects these bodies debate but most seem to agree that there is one yardstick against which the propriety of professional behaviour can be measured. The yardstick exists because our society grants doctors privileges to help them look after their patients properly. Those privileges range from access to powerful drugs to access to confidences about patients' lives. The fundamental ethical offence, as far as I'm concerned, is for a doctor to exploit those privileges for reasons other than the patient's interest.

Recent judgments of the Disciplinary Committee suggest its members use this yardstick when judging doctors' behaviour and it is not a bad starting point for further debate. At least it subverts the oft-made criticism that doctors create "medical ethics" to protect their own interests rather than those of their patients.

Summary of Cases considered in 1978

(a) *The Penal Cases Committee*

The Committee held three meetings in 1978 and considered 94 cases of conviction or conduct. It referred 28 cases for inquiry by the Disciplinary Committee and directed that a letter conveying a warning should be sent to the doctors concerned in 52 other cases. In 10 cases, the Committee directed that no action should be taken, and in the 4 remaining cases consideration was postponed until 1979 in order that further information could be obtained.

The Committee noticed a small decrease in 1978, compared with recent years, in the number of convictions for offences involving dishonesty. The majority of cases in this category continued to be for shoplifting. The Committee expect doctors who behave in this way to consider why they have done so with a view to ensuring that there is no repetition of such conduct. In addition, the Committee noted a small increase in 1978, compared with recent years, in the number of convictions involving an abuse of alcohol. These were mainly for drunken driving and cognate offences. As stated in the Council's blue pamphlet on Professional Conduct and Discipline, successive convictions for offences of this kind may lead to an inquiry before the Disciplinary Committee.

Cases considered by the Committee covered a considerable range. For example, one case involved a conviction for manslaughter. An unusual case related to nine doctors employed at a hospital who were convicted of dishonestly using electricity without due authority. In effect, they operated a system whereby they were able to make personal long distance telephone calls, including calls overseas, from the hospital without paying their employing authority. Although the Committee decided not to refer the case for inquiry by the Disciplinary Committee, partly in view of the not inconsiderable fines that had already been imposed, they instructed that letters sent to each of the nine doctors should include a warning that if information about them relating to any further conviction for an offence involving dishonesty were to be received by the Council, a charge might then be formulated against them on the basis of both the earlier and the later convictions, and an inquiry into the charge held by the Disciplinary Committee.

From time to time the Council receives complaints from hospital authorities about doctors who accept appointments offered to them and who later, and sometimes without any prior warning or apology, fail to take up those appointments. In the majority of such cases, the doctors have subsequently obtained a more attractive appointment at another hospital. A case of this kind was referred to the Committee in 1978 where the doctor had falsely claimed to the hospital authority concerned that illness had prevented him from taking up his appointment and had thereafter lied in a number of respects when questioned by that authority. He had, in the meantime, commenced an appointment at another hospital. In view of a written undertaking by the doctor that at no time in the future would he behave in such a way again, the Committee determined that no inquiry should be held by the Disciplinary Committee in the case.

Another case involved two doctors who were each convicted of conspiracy in respect of a number of offences under the Misuse of Drugs Act 1971. They were part of an organisation which illegally manufactured and distributed on a massive scale quantities of LSD tablets. The persons, including the two doctors, engaged in this activity were brought to trial following a prolonged undercover investigation by the Police which became known as "Operation Julie". The Committee determined that the case of each doctor should be referred for inquiry by the Disciplinary Committee subject, in the case of one of the doctors, to the outcome of an appeal against sentence. The appeal has not yet been heard. The name of the other doctor was erased from the Register by direction of the Disciplinary Committee.

During 1978, the Penal Cases Committee also referred for inquiry by the Disciplinary Committee three cases of doctors whose prescribing of controlled drugs, or of other drugs liable to lead to abuse or dependence, was alleged to be irresponsible or otherwise than in the course of bona fide treatment. In one of these cases, it was alleged that the doctor had, on numerous occasions, prescribed large quantities of controlled drugs on payment to him by patients, and other persons, of £1 per tablet. His name was removed from the Register by direction of the Disciplinary Committee. In one of the other cases, the Disciplinary Committee determined that the registration of the doctor should be suspended for six months and that the suspension should be imposed immediately. In the remaining case the Committee decided to

postpone judgment and thereby keep the doctor under their surveillance.

A summary of the cases considered by the Penal Cases Committee is provided in Table A on page 25.

(b) *The Disciplinary Committee*

Paragraphs 321-2 of the Merrison Report included the following sentences:

> 321. At present, Disciplinary Committee hearings are in public, but the Committee reaches its decisions in private. The hearing may very occasionally be in camera if matters of delicacy are involved. There are no restrictions on press reporting of proceedings, although in practice the press respects a request from the Disciplinary Committee Chairman that the anonymity of a party to the proceedings be preserved.
>
> 322. The very strong feelings that exist over the press reporting of GMC misconduct proceedings came out in evidence to us. The following comment, from a doctor who explained that he devoted three-quarters of his time to medical journalism, was typical.
>
> "To subject a man to a week of headlines like *'Sex on the Surgery Couch'* is to punish him. The fact that he may be found not guilty at the week's end does not erase the headline from people's memories."

The report went on to recommend that the publicity given to misconduct proceedings should be controlled by legislation. In the event however the Medical Act 1978 did not include any provision to implement this recommendation, and indeed re-enacted the requirement of previous Medical Acts that proceedings before the Disciplinary Committee should be held in public except insofar as may be provided by the Committee's Rules of Procedure. While the Medical Act was before Parliament this matter attracted some comment and criticism, and the Council, after obtaining legal advice, agreed that the Rules governing the procedure of the Disciplinary Committee should be modified so as to make it somewhat easier than before for cases to be heard in camera. As revised the Rules now provide that if any party to any proceedings or any witness therein makes an application for the public (and thereby the press) to be excluded, then if it appears to the Committee that any person would suffer undue prejudice from a public hearing or that for any other reason the circumstances and nature of the case make a public hearing unnecessary or undesirable, the Committee may direct that the public and press shall be excluded. The amended Rules also provide that even where no such application has been made the Committee may of their own initiative direct that the public and press shall be excluded if it appears to them after

hearing the views of the parties thereon that to do so would be in the interests of justice or desirable having regard to the nature either of the case or of the evidence to be given. The new Rules containing these provisions were approved by the Privy Council in December, 1978.

In 1978 the Disciplinary Committee held meetings in March, July and November on seventeen days. 2 of the 28 new cases referred to it for inquiry were postponed until 1979 pending the outcome of appeals made by the doctors concerned against the sentences imposed on them by the courts. The Committee therefore considered 26 new cases and, in addition, reconsidered 10 cases on which judgment was postponed or a period of suspension was imposed in 1977. Restoration to the Register following disciplinary erasure was directed in 3 out of 5 cases considered.

Two cases referred to the Disciplinary Committee each involved doctors who, over a period of years, had deliberately defrauded the National Health Service. In the first case the doctor had, in conjunction with a number of pharmacists, obtained by deception reimbursement for drugs which had, in fact, not been supplied to him. The Committee ordered that his registration should be suspended for 12 months. In the second case, the doctor had obtained by deception reimbursement in respect of receptionists and other ancillary staff whom he had, in fact, not employed. The doctor subsequently repaid the full sum of money he had thereby gained illegally. In all the circumstances, the Committee determined to admonish the doctor.

It is widely believed that the Disciplinary Committee concentrates its attention on cases where it is alleged that a doctor has abused his professional position by forming a personal relationship of an emotional or sexual nature with a patient and has, thereby, committed serious professional misconduct. In fact, cases in this category form but a small part of the work of the Committee. For example in 1978, a not untypical year, there were two such cases out of the 36 cases considered by the Committee. Neither case resulted in erasure or suspension. In the last 4 years, 9 cases in this category have been considered by the Committee (out of a total of 170 cases). Of these, 1 resulted in the erasure of the doctor's name from the Register, 3 in the suspension of the doctor's registration (in 2 cases, the period of suspension imposed was three months, and in the remaining case eleven months), 3 other cases resulted in a finding of serious professional misconduct against the doctors who

were admonished, and in the remaining 2 cases the Committee found that the doctors were not guilty of serious professional misconduct.

A summary of the work undertaken by the Disciplinary Committee is provided in Table B on page 26. A number of cases involved more than one element. For example, one of the cases listed under "1. Abuse of Alcohol" in the Table also involved a conviction for criminal damage, improper behaviour towards a patient and disregard of personal responsibilities by the practitioner to his patients.

Other matters

The Council received during the year 884 letters from members of the public or the profession relating to matters of professional conduct. These letters were 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 hospital doctor, writing on behalf of his colleagues and himself, who sought advice on the following situation. Permission had been granted by the hospital authorities for an illustrated article to be prepared for publication in a national newspaper on the work undertaken at the hospital, subject to scrutiny of the article in draft before publication. No mention had been made about anonymity for the staff of the hospital. When the draft was presented, however, it was found to include the names of a number of doctors at the hospital, together with photographs, and accounts of their professional skills and services. The representatives of the newspaper subsequently refused a request by the hospital authorities to delete the names of the doctors from the draft, and the article was in due course published. The doctor who had written to the Council was referred to the advice on advertising set out in the blue pamphlet on Professional Conduct and Discipline. This pamphlet also indicates that doctors who seek detailed advice on professional conduct in particular circumstances should consult a medical defence society or professional association.

The Council received from doctors and also from members of the public a number of complaints in cases where the facilities and services offered by clinics, nursing homes and similar organisations had been advertised in the lay-press. Advertisements of this kind

do not, of themselves, raise a matter in which the Council could undertake to intervene in the exercise of its disciplinary jurisdiction unless there is evidence to show that one or more persons, whose names were given and who can be identified as registered medical practitioners, had been connected with the organisation. The Council's blue pamphlet indicates the principles which should govern the professional conduct of individual practitioners who may be connected with organisations which advertise clinical or diagnostic services to the lay-public. Copies of the blue pamphlet may be obtained on application to the Registrar of the Council.

(A) **Work of the Penal Cases Committee in 1978**

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[a]	2	–	—	–
2 Abuse of alcohol	29	–	29	3	–	3
3 Abuse of drugs						
(a) Personal abuse	8	3[b]	11	4	2	6
(b) Offences under the Misuse of Drugs Act 1971, not relating to personal abuse	5	–	5	4[f]	–	4
4 Non bona fide prescribing or supplying to others of drugs of addiction	3	–	3	3	–	3
5 Illegal Abortion	1	–	1	1[g]	–	1
6 Personal relationship of an emotional or sexual nature with a patient	–	2	2	–	1	1
7 Dishonesty	13[c]	3	16	4	2	6
8 Violence	2	–	2	–	–	–
9 Indecency	9[d]	–	9	4	–	4
10 Advertising or canvassing	–	4[e]	4	–	–	–
11 False certification	2	–	2	–	–	–
12 Breach of Professional Confidence	–	1	1	–	–	–
13 Other Charges	4	3	7	–	–	–
Total:	76	18	94	23	5	28

a. Includes 1 case adjourned to 1979
b. Includes 1 case where the doctor's name was subsequently removed from the Register at his own request
c. Includes 1 case adjourned to 1979
d. Includes 1 case adjourned to 1979
e. Includes 1 case adjourned to 1979
f. Includes 1 case referred to the Disciplinary Committee subject to the outcome of an appeal against sentence
g. Referred to the Disciplinary Committee subject to the outcome of an appeal against sentence

(B) **Work of the Disciplinary Committee in 1978**

Nature of Cases	*Cases considered*			*Determination of the Disciplinary Committee*			
	Convictions	*Alleged Serious Professional Misconduct*	*Total*	*Erasure*	*Suspension*	*Judgment Postponed*	*Other Action*
1 Abuse of Alcohol	4	1	5	–	–	5	–
2 Abuse of drugs							
(a) Personal abuse	9	3	12	–	3	5	4
(b) Offences under the Misuse of Drugs Act 1971, not relating to personal abuse	2	–	2	1	–	1	–
3 Non bona fide prescribing or supplying to others of drugs of addiction	1	2	3	1	1	1	–
4 Abuse of professional position by forming a personal relationship of an emotional or sexual nature with a patient	–	2	2	–	–	–	2
5 Dishonesty	6	2	8	2	2	2	2
6 Violence	1	–	1	–	–	1	–
7 Indecency							
(a) Offences involving abuse of professional position	1	–	1	–	–	1	–
(b) Offences committed in other than professional context	2	–	2	–	–	1	1
Total:	26	10	36	4	6	17	9[a]

a. The nine cases in which "other action" was taken by the Disciplinary Committee comprised 5 cases of conviction where the doctors were admonished; 1 case of conviction in which the doctor's registration had earlier been suspended but no further order was made when the case was reviewed; 2 cases of conduct in which the doctors were admonished after being found guilty of serious professional misconduct; and 1 case of conduct in which the doctor was found not guilty of serious professional misconduct.

Full registration

During 1978 full registration was granted to 2,669 overseas-qualified doctors (excluding those registered after re-qualification in the United Kingdom). This number was 141 less than the 2,810 such doctors to whom full registration was granted during 1977. Over the period from January to September, 1978, full registration was granted to 1,614 overseas-qualified doctors, 23% fewer than over the equivalent period of 1977. But advance publicity given to the introduction from December 1, 1978, of the new language requirement for full registration gave rise to a spate of applications for full registration during October and November, 1978. During those months, full registration was granted to numerous doctors who had qualified in the countries affected by the introduction of the language requirement, as follows (the figures for the numbers of doctors from those countries who were granted full registration during the equivalent period of 1977 are given in brackets):

Burma	256	(13)
India	467	(147)
Sri Lanka	82	(16)
	805	(176)

During the year, the Council received information that the Newfoundland Medical Board had revised the conditions for registration there of British-qualified doctors. On the recommendation of the Council, an order was made by the Privy Council which terminated the right of doctors to be granted full registration in the United Kingdom by reason of qualifications granted in Newfoundland.

In response to invitations which arose from an application for recognition of the BM degree of the University of the Orange Free State, a delegation visited medical schools in the Republic of South Africa on behalf of the Council in April, 1978. In the light of their report the Overseas Committee agreed to recognise for full registration the Orange Free State University degree, and to continue to recognise for that purpose medical degrees granted by the Universities of Cape Town, Pretoria, Stellenbosch, and the Witwatersrand. Medical degrees of the University of Natal will also continue to be recognised for full registration, subject to further review after a period of three years.

The total numbers of full registrations granted during 1978 to doctors who had qualified in various countries were as follows (the 1977 figures are given in brackets):

Australia	425	(489)	Malta	4	(39)
Burma	360	(123)	New Zealand	105	(80)
Canada	37	(30)	Singapore	30	(77)
East Africa	25	(19)	South Africa	189	(299)
Hong Kong	53	(101)	Sri Lanka	167	(98)
India	1197	(1335)	West Indies	30	(31)
Malaysia	47	(89)			

Temporary registration

During 1978 11,041 Certificates of Temporary Registration were issued; this number was very similar to the number of certificates issued in 1977 (11,086). The number of doctors granted temporary registration for the first time rose from 1,124 in 1977 to 1,365 in 1978. The countries where most of the doctors granted temporary registration for the first time during 1978 had qualified were as follows:

Egypt	177	Pakistan	40
Iraq	160	Canada	31
India	145	Iran	30
USA	94	Italy	28
Nigeria	78	USSR	23
Sri Lanka	48	Sudan	20
Greece	45		

The number of entries in the Register of Temporarily Registered Medical Practitioners fell from 5,982 on January 1, 1978, to 4,339 on January 2, 1979. On average, a doctor practising under temporary registration obtained at least two certificates of temporary registration over the course of the year. It also appears that a significant proportion of the doctors who had practised under temporary registration in 1977 had either left the United Kingdom or were unemployed at the beginning of 1979.

The TRAB test

During 1978 the Temporary Registration Assessment Board conducted eleven tests in the United Kingdom. Of 1828 candidates, 770 passed. 806 of the candidates were attempting the test on a second or subsequent occasion.

In November, 1978 the Board provided facilities for candidates to take the two computer-marked sections of the test in advance at an overseas centre, in Baghdad. Of 79 candidates, 31 passed both the computer-marked sections.

TRAB TESTS (January – December, 1978 inclusive)

Schedule of results by country of qualification

Country of qualification	*No. of candidates*	*No. of passes*
Egypt	411	147
India	405	150
Iraq	346	177
Pakistan	113	42
Nigeria	103	68
Sri Lanka	63	55
USSR	42	11
Bangladesh	36	10
Syria	33	9
Iran	31	12
Greece	29	10
Sudan	25	16
Taiwan	19	6
Poland	17	6
Spain	13	2
Dominican Republic	11	3
Ghana	10	5
Yugoslavia	10	3
34 other countries	111	38
Total	1828	770

From January 1, 1979 the title of the Board was changed. It is now the Professional and Linguistic Assessments Board (PLAB).

FINANCE

The following summary shows the main items of the Council's income and expenditure for 1978:

Income		*Expenditure*	
Annual retention fees	£650,364	Education	£ 25,069
Fees for provisional or full registration:		Professional conduct and discipline	£125,377
British and Irish doctors	£170,380	Registration of British and Irish doctors	£ 44,203
Overseas doctors	£186,244	Registration of EEC doctors and associated activities	£ 21,913
Fees for EEC registrations and certificates	£ 10,308	Registration of overseas doctors	£177,541
Fees received for temporary registration of overseas doctors	£212,145	TRAB tests	£119,172
		Maintenance of Register	£ 80,265
Fees received from candidates for the TRAB tests	£141,243	Collection of annual retention fees	£132,703
Fees for issuing miscellaneous certificates	£ 19,705	Publication of Medical Register and Fortnightly Lists	£ 42,736
Sales of Medical Register and Fortnightly Lists	£ 48,903	General administration	£311,522
Net investment income and other sources	£ 40,951	Payment to staff Superannuation Fund in respect of increased liability for past service arising from inflation	£ 22,969
Total:	£1,480,243	*Total:*	£1,103,470

The sum shown as expenditure on general administration represents expenditure which cannot realistically be apportioned amongst other headings – for example, meetings of the Council, cost of staff employed on common services, charges for legal, actuarial or financial advice, and alterations to premises in preparation for the enlarged Council.

During 1978 the Council's expenditure and income both increased. The increase in expenditure, which amounted to less than 10%, was mainly due to inflation. Most of the increase in income came from the fees paid on provisional and full registration

which were increased with effect from January 1, 1978. Fees received from candidates for the TRAB tests and for temporary registration also rose substantially. In particular during 1978 the whole of the expenditure incurred on conducting the TRAB tests was for the first time covered by the fees paid by candidates.

In November, 1978, the Council decided to increase the annual retention fee with effect from May 1, 1979, from £8 to £10. This fee had not been increased since 1976. The increase was considered necessary to provide a sound financial basis for the new Council expected to meet in September, 1979, to cover the effect of inflation (which increases most of the Council's expenditure but does not in itself increase any of its income), and because a substantial fall in income from the registration of overseas qualified doctors is likely to occur in 1980 and subsequent years.

The Council also decided when the amount of the annual retention fee is increased on May 1, 1979, to introduce, as an alternative method of payment of the fee to payment by cheque or by standing order, the method of payment known as the variable amount direct debit. This arrangement, which has been adopted by the British Medical Association and some other professional bodies, should eventually reduce the cost of collection of the annual retention fee if a substantial number of doctors agree to pay their fees by this method. Under it a doctor authorises the Council to debit his bank account for the amount of the annual retention fee.

Under the variable amount direct debit system the position of the doctor is safeguarded in several ways. The Privy Council must approve any change in the amount of the annual retention fee and the Council has undertaken to notify all doctors who choose to pay by this method on each occasion when the amount of the annual retention fee is changed. The doctor may cancel his mandate at any time, and if a doctor's account is accidentally debited by any amount other than that of the annual retention fee, he is protected by an indemnity which the Council has given to the clearing banks.

Unlike a standing order, the direct debit mandate given by the doctor does not need to be altered on each occasion when the amount of the annual retention fee is increased. Previously, on each occasion when the annual retention fee has been increased it has been necessary to communicate with each doctor paying the fee by standing order and invite him to alter his order. Payment by direct debit will avoid this. By the end of 1978 approximately

12,000 doctors had made standing orders for payment of the fee at the old rate of £8, and it will cost the Council £14,000 to deal with the changes in their standing orders which the increase in the fee makes necessary. These doctors are being invited to change to the variable amount direct debit system and the Council hopes that subsequently many other doctors will be willing to use this method of payment. To the extent that this occurs it should be possible in future progressively to contain the cost of the collection of annual retention fees.

Copies of the Council's accounts for 1978 may be obtained from the Registrar on request.

WHERE ARE YOU?

Every year the names of a number of doctors are erased from the Register because their registered address has become ineffective. In consequence communications from the Council fail to reach them, and so the doctors do not reply or omit to pay their annual retention fee. If you change your address, please notify the Registrar in writing. You should then receive a letter confirming that your new address has been registered. If you do not receive such a letter, please check the position.

This Report is being sent to practitioners at the addresses shown in the Register on April 12, 1979. Any change of address notified on or after that date will be included in the Register if you have received a letter confirming this.

The Council's address is 44 Hallam Street, London, W1N 6AE, and its telephone number is 01-580 7642.

In May, 1978, the Council lost through retirement Professor Archibald Duncan DSC, FRCOG, who had served on the Council as the representative of the University of Edinburgh from October 1, 1974. In his comparatively short time on the Council, Professor Duncan served on many Committees, including the Executive Committee, the Education Committee, the Overseas Committee, the Penal Cases Committee and the Registration Committee, as well as various Sub-Committees. He is succeeded by Professor James Williamson, FRCP Edin.

During the year six former members of the Council died:

Sir David Campbell, MC, MD, served on the Council for twenty-five years as member for the University of Aberdeen from 1936, and was President of the Council from November, 1949, until his retirement in 1961. Sir David was Chairman of the Disciplinary Committee from its inception in 1951, and was largely responsible for the work leading to the publication of the Recommendations as to the Medical Curriculum, published in 1957. He was the first President of the Council to visit medical schools in all parts of the Commonwealth on behalf of the Council.

Dr. Trevor Bryant, OBE, MB, served on the Council as an elected member for England and Wales for five years from April, 1966.

Dr. George Ireland, OBE, MB, retired from the Council in April, 1971, after nineteen years as an elected member for Scotland.

Sir Hector MacLennan, FRCOG, was the representative of the Royal College of Obstetricians and Gynaecologists for five years until January, 1970.

Professor James McLeod, OBE, FRCPath, FRS, represented the University of Leeds from July, 1950, to November, 1952.

Dr. Francis O'Donnell, FRCP Irel, represented the Apothecaries Hall, Dublin, for ten years until January, 1973.

The year also saw the death of Mr. Walter Pyke-Lees who was Registrar of the Council from 1951 until 1970.

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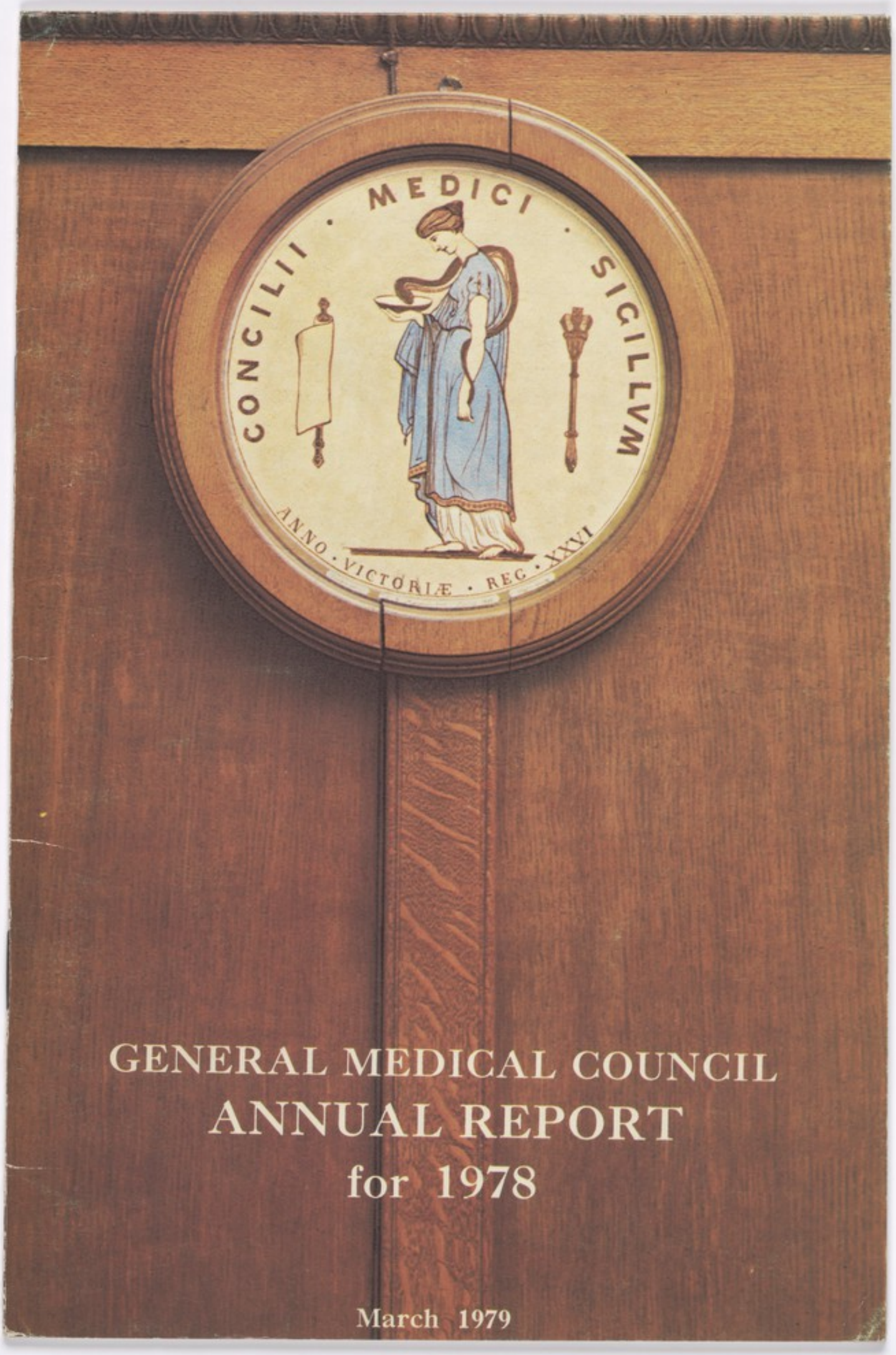

GENERAL MEDICAL COUNCIL
ANNUAL REPORT
for 1978

March 1979