Understanding the GMC

The General Council of Medical Education and Registration, now the General Medical Council (GMC), was established in 1858 to maintain a register of qualified medical practitioners so that the public could distinguish qualified doctors from the unqualified.

The Council was given power to set the educational criteria for inclusion in the register, a power which its education committee retains. It also acquired powers to remove those who were unfit to practise from its register, and later established a committee on standards and ethics to provide guidance to doctors on the professional behaviour expected of registered practitioners. Registration, education, fitness to practise and standards remain the four core functions of the GMC to the present day.

PRIVILEGES OF REGISTRATION

While there is in the UK no legal impediment to unqualified practitioners treating the sick, and much treatment is provided by osteopaths, chiropodists and other practitioners, a number of key privileges are restricted by law to those registered with the GMC, notably the right to prescribe controlled drugs, the right to sign certain legal documents such as death certificates and the right to be employed as a doctor in the NHS. The fact that parliament allows these privileges to be awarded by a body more than half of whose members are elected by the medical profession implies a contract between doctors and society.

The GMC regulates the medical profession in the public interest and the privilege of professional self-regulation depends on its being seen to do this.

SERVING THE PUBLIC INTEREST

During the 1990s, a succession of initiatives have emphasized the GMC's commitment to serving the public interest. The number of lay members has doubled, so they now comprise approximately a quarter of the Council, and lay members chair the preliminary proceedings committee and some conduct committee panels.

The Council's booklet *Good Medical Practice* (GMC, 1995) has made explicit the standards of care and conduct which the public have a right to expect of their doctors. New guidance on undergraduate and postgraduate medical training emphasizes the importance of communication skills, ethical awareness, reflective practice and lifelong learning.

Despite this, the GMC has recently been subject to adverse comment in the media, from politicians and even from doctors. Almost invariably, these comments relate to its fitness to practise function, specifically to its handling of conduct cases. It is accused of being slow, unresponsive to complainants and sometimes misguided in its judgments. The courts, whose procedures the GMC follows closely, are often similarly criticized. In both settings, human rights legislation demands a presumption of innocence unless the accused is proved guilty 'beyond reasonable doubt'.

The need to collect evidence in each case which will stand up to legal scrutiny and, meanwhile, to avoid comment which might be seen as prejudicial to a fair hearing can make the GMC's procedures appear cumbersome and opaque. Almost any conduct panel's decision can be seen as too harsh or too lenient by the complainant, the respondent doctor or journalists and politicians. As with court proceedings, it is almost inevitable that one or other party will be dissatisfied with the outcome.

'FITNESS TO PRACTISE'

The GMC is nonetheless committed to fairness and openness and the fitness to practise procedures continue to develop rapidly. Until 1980, the GMC had only one 'disciplinary' process. At that time, the number of complaints to the GMC was small, but these included doctors who were mentally ill or addicted to alcohol or drugs. Separate health procedures were introduced in 1980, allowing sick doctors to be dealt with in a more humane but still effective way.

There remained a problem with doctors referred to the conduct procedures who could not be shown to be guilty of a single act of 'serious professional misconduct' but who appeared to exhibit a pattern of consistently poor performance. Following amendment of the Medical Act 1983, the 'performance procedures' were instituted in 1997 to deal with this group of doctors.

During the 1990s, the workload of the fitness to practise section of the Council has massively increased. The number of complaints received each year by the GMC has risen to over 3000 in 1999, but other changes have also occurred. In response to legal advice, the proportion of cases reaching a hearing, rather than being dismissed for lack of evidence or dealt with by a warning or advisory letter, has increased.

The duration of hearings before the professional conduct committee has also increased. This is partly because of the extreme complexity of some cases but also because of a greater readiness of respondent doctors and their legal advisors to resort to judicial review of decisions or to appeal to the privy council, and the consequent need to ensure that due legal process has been followed to the letter. The provisions of the Human Rights Act which comes into force this year are likely to increase legal complexity still further.

In the 1950s the disciplinary committee sat for an average of 6 days each year, and in the 1980s the professional conduct committee sat for an average of

43 days. At present, there are over 150 cases awaiting hearing and this year conduct committees will sit for well over 300 days, with two and occasionally three panels in session simultaneously. Despite this, the backlog of cases is likely to increase rather than diminish. Members of the GMC, both medical and lay, are being asked to serve on committees for up to 10 weeks a year. While some who have retired from practice can offer this amount of time, many find it extremely difficult to combine service on the GMC with clinical commitments.

CHANGING THE GMC

This situation clearly cannot continue, and on 9 February 2000 the GMC asked the Secretary of State to allow non-members of the GMC to sit on fitness to practise panels. The way in which such individuals will be selected and trained remains to be decided, but the development is essential if the GMC is to achieve acceptable standards of service both to complainants and doctors.

Some of the criticisms of the GMC result from a misunderstanding of the significance of registration by the public, politicians, the media and doctors. Surveys have shown that the public believe that entry in the register indicates current competence (GMC, 2000). In fact, it only indicates that the doctor has at some time acquired a GMC-accepted qualification, has continued to pay the annual retention fee and has not been proved unfit to practise.

The presumption that a practitioner who is qualified will thereafter remain fit to practise may have been legitimate during the first 100 years of the GMC's existence, but it is scarcely so in the rapidly changing context of present-day medicine. This is especially true in view of the known reluctance of professionals to take action when they suspect that a doctor may be unfit to practise.

REVALIDATION

In the light of this, the Council has decided that, in order to remain on the register, doctors will in future have to produce evidence of their continuing fitness to practise at regular intervals, probably every 5 years. Those who fail to produce such evidence will lose their registration. Those who produce evidence which raises concerns about their fitness to practise will be referred to the Council's fitness to practise procedures (usually the performance procedure).

This increases the complexity of maintaining the register. It raises questions about the handling of doctors who are retired, working abroad, taking career breaks or working in a non-clinical capacity. There will be particular difficulties in obtaining reliable evidence about locums, doctors who work in isolation and those in unusual roles.

Assessing evidence of fitness to practise from the 100 000 or so doctors believed to be in active practice in the UK would represent a workload well beyond anything which the GMC's members or staff could cope with, and revalidation will depend upon these assessments being carried out close to each doctor's place of work by individuals acceptable to the GMC. Specifying who these people should be, defining the evidence they should consider and ensuring that judgments are consistent across the country and between specialties all present tremendous challenges.

Revalidation has generated understandable concern among doctors, most of whom are providing a good standard of care, often in circumstances in which they are hard pressed and short of resources. Although the vast majority have nothing to fear from revalidation, the time it will take to collect evidence and have it approved represents a further call on their time which could detract from direct patient care.

Even though revalidation in the NHS will draw heavily on the results of clinical governance, there is a difficult balance to be struck between ensuring that revalidation is robust enough to enjoy public confidence while avoiding an unnecessarily burdensome and intrusive scrutiny of doctors who are performing well in order to detect a small minority who are performing poorly.

CONCLUSIONS

The recent history of the GMC is one of rapid change and innovation, from an organization rooted in the 19th century concept of 'the qualified' to one which sees its role as setting explicit standards and ensuring that those standards are met by doctors on its register. It is unlikely that it will ever be loved, either by those it regulates or those who complain to it. For politicians it will remain a convenient whipping boy when things go wrong in the NHS and for journalists it will continue to generate headline-grabbing stories of medical misdemeanour.

In future, it will need to be more adept in communicating its message to its stakeholders if it is to achieve its aims. However, it still remains the best option for regulating the medical profession in the public interest. The fact that doctors bear the cost — some £30 million a year and rising — must make alternatives unattractive to government. **HM**

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GMC (1995) *Good Medical Practice.* GMC, London
GMC (2000) *Mori Poll: Attitudes Towards Doctors and their Code of Conduct.* GMC, London

KEY POINTS

- The General Medical Council (GMC) is charged with regulating the medical profession in the public interest and the privilege of professional self-regulation depends upon its being seen to do so.
- Through its booklet *Good Medical Practice* the GMC has made explicit the standards of care and conduct which the public have a right to expect of their doctors.
- In order to achieve acceptable standards of service to both complainants and respondent doctors, the GMC needs powers to include non-members on its conduct panels.
- The public expects that inclusion in the medical register indicates that a doctor is up to date and fit to practise.
- In future, doctors will have to provide evidence that they are up to date and fit to practise as a condition of remaining on the register — the process of revalidation.
- There is a difficult balance to be struck between ensuring that revalidation is robust while avoiding an unnecessarily burdensome scrutiny which could detract from direct patient care.