The day of judgment comes closer

Richard Smith

The General Medical Council feels misunderstood. In the past few months I have spoken to many members of the council and to staff, and without exception they have rued the misapprehensions about the council. Some spoke disparagingly of recent criticisms of the council,[1 2] arguing that they too are full of errors. Most of the population does not know the difference between the BMA and the GMC, and neither, it seems, do some doctors and medical students. To the mass of the population the GMC is if anything an old fashioned body concerned primarily with doctors' sexual peccadillos. To a vocal few it is a body that puts the professional interest before that of the public. To most doctors the GMC is a remote body that spells trouble: it is best ignored.

This series of articles, which comes as the next round of elections to the council begins, is an attempt to look critically at the council and what it does. Many of those whom I interviewed thought that changes will have to be made and that we will eventually need a change in the Medical Act, the legislation that covers the activities of the GMC. The most fundamental question, which was hardly addressed by the 1975 Merrison inquiry into the council,[3] is whether self regulation of doctors is still acceptable. Some think that it is not.[4]

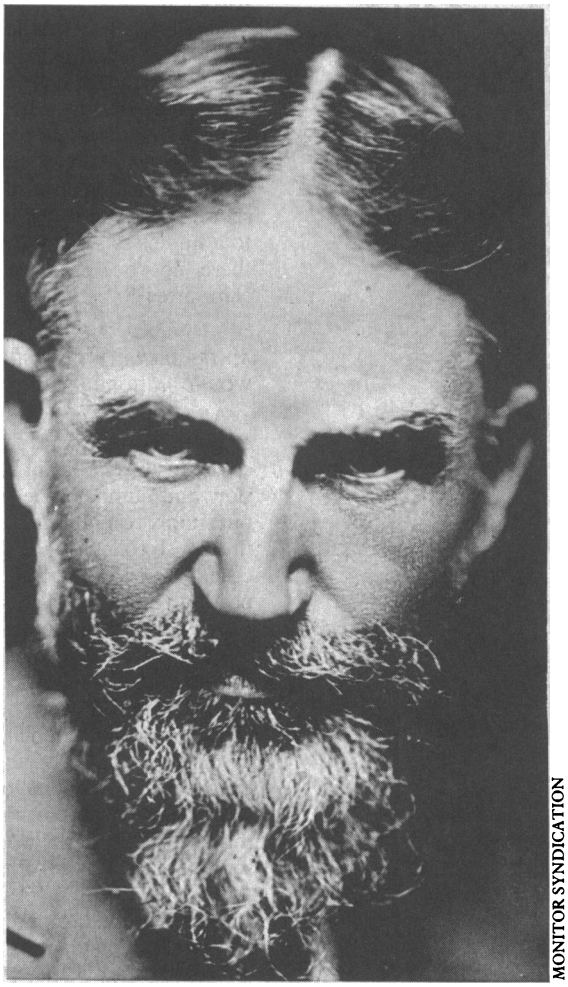
Views of the GMC

A NINETEENTH CENTURY INSTITUTION LOST IN THE TWENTIETH CENTURY

One view of the GMC is that it is a nineteenth century institution trying—and largely failing—to adapt to the late twentieth century. It is seen as progressively losing touch with a fast changing world.

Much greater accountability is being demanded from all professions, and litigation against doctors and other professionals is increasing rapidly.[5] The public, or at least its representatives, is more questioning of doctors and is doubtful that the GMC is capable of maintaining standards and willing to discipline any but the most wildly errant doctors. Members of parliament have been pushing the council to do more about doctors committing offences more minor than "serious professional misconduct."[6] Doctors themselves are worried that the council does too little to help members of the profession who have lapsed into incompetence,[7] and how to deal with incompetent doctors is one of the issues that concern the council most.[8]

A right wing government is, meanwhile, suspicious of professional monopolies and is encouraging more market oriented thinking in both the health service and the universities, weakening the influence of the GMC. The council has been worried by the way in which reduced resources may cause a fall in standards of both training and practice.[9] And the growth in private practice poses a particular threat to the authority of the GMC: the private sector does not have the complaints machinery of the NHS, and the GMC does not yet have a mechanism for curtailing those poorly trained doctors in the private sector who describe themselves as specialists. The recent scandal of a doctor selling unethical treatments for AIDS in a private hospital has illustrated some of these difficulties.[10] Meanwhile, the government has accepted the recent report from the Monopolies and Mergers Commission that recommended advertising by general practitioners and will if necessary oblige the council to accept such advertising.[11]



MONITOR SYNDICATION

George Bernard Shaw

"All professions are a conspiracy against the laity."

Members of the GMC regard supervising education rather than discipline as its most important job, and they resent its educational work receiving much less attention than its disciplinary work. But education is also changing fast. Dissatisfaction with medical education runs deep among teachers and students, and it is unusual to meet young doctors who talk glowingly of their education. Much of the dissatisfaction stems from more and more being incorporated into medical courses; some educationalists argue that rather than producing recommendations on what should be included in the undergraduate course the GMC should be concentrating on what might be left out.[12] The council has acknowledged that overcrowding in undergraduate courses is a problem[13] but has not been successful in solving it. Experiments in medical educa-

British Medical Journal, London WC1H 9JR
Richard Smith, MB, *senior assistant editor*

Br Med J 1989;298:1241-4

tion in Britain have not been as innovatory as those in some medical schools in Canada, Australia, the United States, and The Netherlands; how much the GMC has inhibited innovation is a point for debate.

Educationalists point out that education is no longer an amateur activity, and yet the education committee of the council does not statutorily include specialists in education (but does at the moment contain two doctors who are specialists in education). Despite the widespread unhappiness with undergraduate medical education attention is shifting to postgraduate and continuing education, and the GMC has a working party looking at continuing education. Yet this seems to have come very late, and the government rather than the council is taking the initiative in pushing doctors to practise audit routinely.[14]

There are also worries about the council's pronouncements on ever more complex ethical issues. What is the value of such an organisation dominated by doctors ruling on ethical issues such as, for instance, selling kidneys for transplantation or refusing dialysis to a homeless schizophrenic patient? Should in 1989 there not be a predominantly lay national ethics committee?[15]

AN IRRELEVANT TALK SHOP, THE ENVY OF THE WORLD, A HOPE FOR THE FUTURE

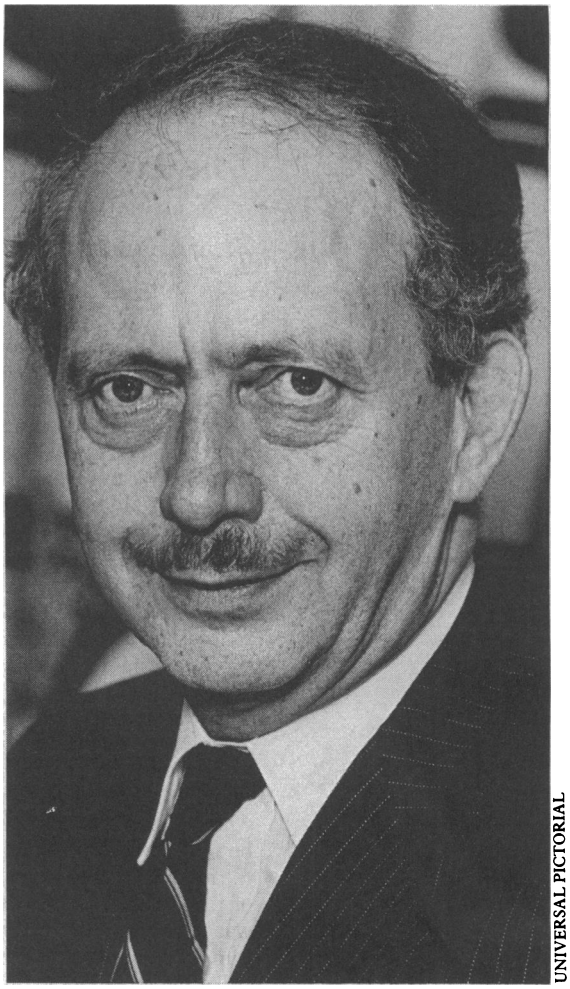
Another view of the GMC is that even if it is slow to adapt to modern times this does not matter because the council is unimportant. It is, according to this view, a slow and cumbersome body that takes no initiatives but simply responds to action taken by the universities, the royal colleges, the BMA, the government, and other groups. This rubber stamping council may thus be left to operate as a cross between a medical House of Lords and a branch of the Rotarians, and those who want to advance medical care in Britain should look elsewhere.

This would not be the view of many of the senior members of the council. They think that it does an excellent job in satisfying the competing demands of public and professional bodies; they believe that it has to work slowly and by consensus. The council is, they think, the envy of the world—and it has been copied in some of the countries of the Commonwealth.

A third view is that every country needs a body to regulate its medical profession and that this should take the lead in adapting doctors to new conditions. A reformed and galvanised GMC might play an important part in leading British medicine into the next century.

Self regulation and the professions

Discussions on the particular problems of the GMC are proceeding within the context of discussions on the value of the professions and the acceptability of self regulation—not only for doctors but also for lawyers, stockbrokers, and other professionals. In Britain the professions have been largely self regulating, and Ralf Dahrendorf, who was director of the London School of Economics and Political Science, sees this as a triumph for Britain and its liberty.[16] All professions have an implied contract with society, and in a lecture to the Royal Society of Medicine Dahrendorf quoted a former president of the Institution of Electrical Engineers: "Professional status is . . . an implied contract to serve society over and beyond all specific duty to client and employer in consideration of the privileges and protection society extends to the profession." "What is special," continued Dahrendorf, "is the notion of an 'implied contract' between society and the professions which has no intermediary, no outside guarantor, and which nevertheless works." All this, said Dahrendorf, a German, is very British—"the distinguishing characteristic of the English professions [is that] the state does not enter into their contract with society." He contended that "the condition of the British professions is an index of the state of liberty in this country and that what they do and what happens to them has a great deal to do with whether Britain remains a model of a free society for the rest."



UNIVERSAL PICTORIAL

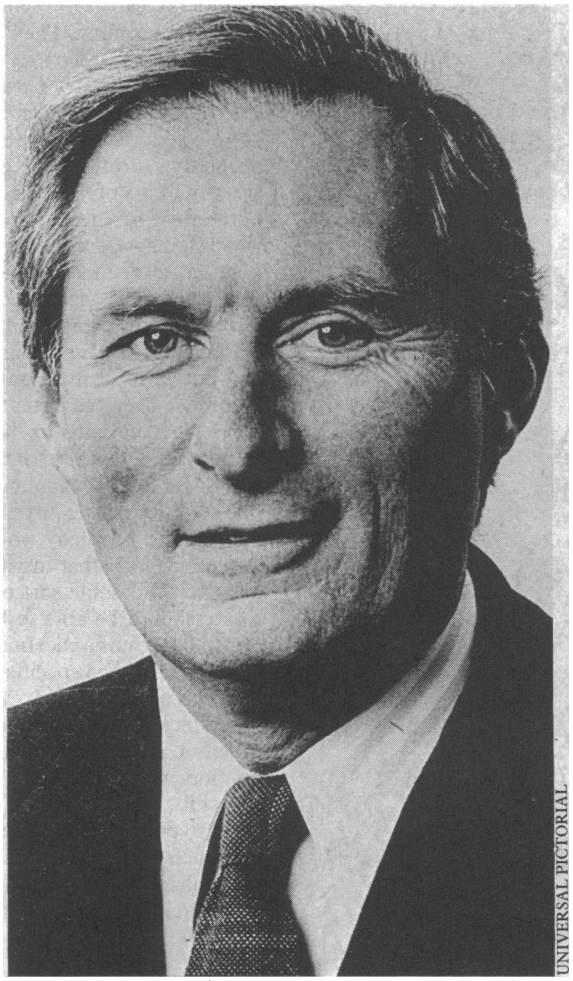
Ralf Dahrendorf

". . . the English professions are a model of the potential of self-government, of an implied contract with society, and thus of liberty. The alternative—the professions bound by the state—is certainly fearful."

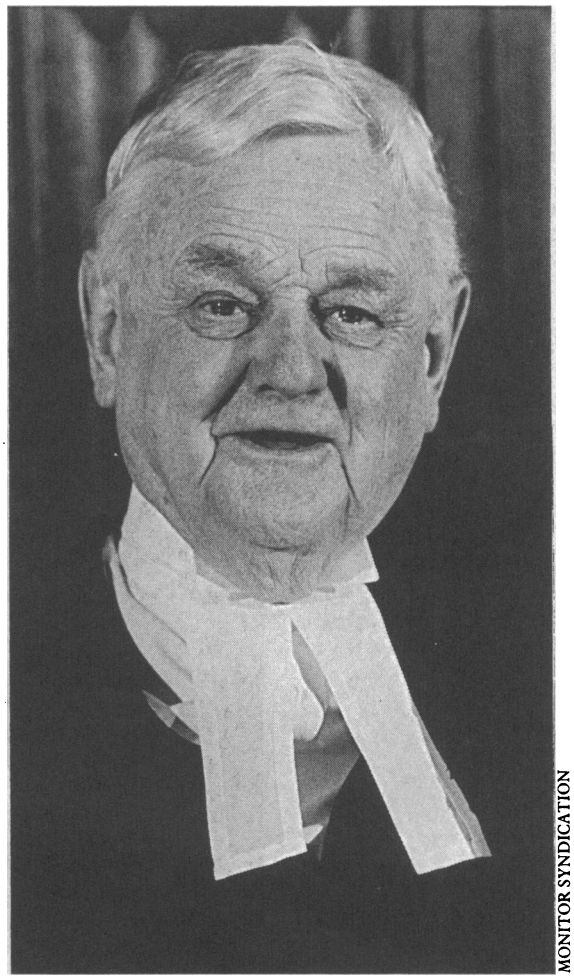
Against this satisfied view of self regulation is the contrary one best expressed by George Bernard Shaw that "all professions are a conspiracy against the laity." Campbell, for instance, argued in last week's *BMJ* (29 April, p 1171) that the GMC's rules about not disparaging other doctors act directly against the public interest when the public is being abused by an unscrupulous doctor. The benign view of the professions has tended to prevail until recently, but now consumer[1,4] and governmental views[11,14] are swinging more towards Shaw's opinion. But suspicion of the power of the professions is not new: Thomas Wakley, a past editor of the *Lancet*, argued at the beginning of the GMC that what was needed for regulation of the profession was an inspectorate in the hands of the Secretary of State.[17]

Self regulation by doctors

Those who believe in the value of the GMC see it as a supreme example of professional self regulation, but some of the critics of the GMC whom I met would like to see the council replaced with a body that is predominantly lay but with medical input. The



Sir Alec Merrison, chairman of the 1975 committee of inquiry into the regulation of the medical profession



Lord Hailsham

". . . the regulation of the medical profession may be regarded as reflecting a mutually advantageous contract between the public and the profession . . . the medical profession has been regulated by a predominantly professional body for well over a century, and evidently a lay regulating body would labour under a substantial disadvantage. It is the essence of a professional skill that it deals with matters unfamiliar to the layman, and it follows that only those in the profession are in a position to judge many of the matters of standards of professional competence and conduct which will be involved. We are in no doubt that the community will indeed be best served by a professional regulating body."

". . . professions have their own machinery [of regulation], some of it statutory, some evolved by custom, but all in the end controlled by the need to provide an adequate and skilled service to the public. Any attempt to impose from without a crude and ideological framework in the interests of competition, not based on the scholarship, experience, and skill required of the particular disciplines involved, will not only result in a weakened service to the public but will also undermine the independence and vigour of a particularly valuable element of a free society."[21]

Merrison inquiry mentioned and dismissed this possibility (see above) but did not consider the arguments in detail.[18]

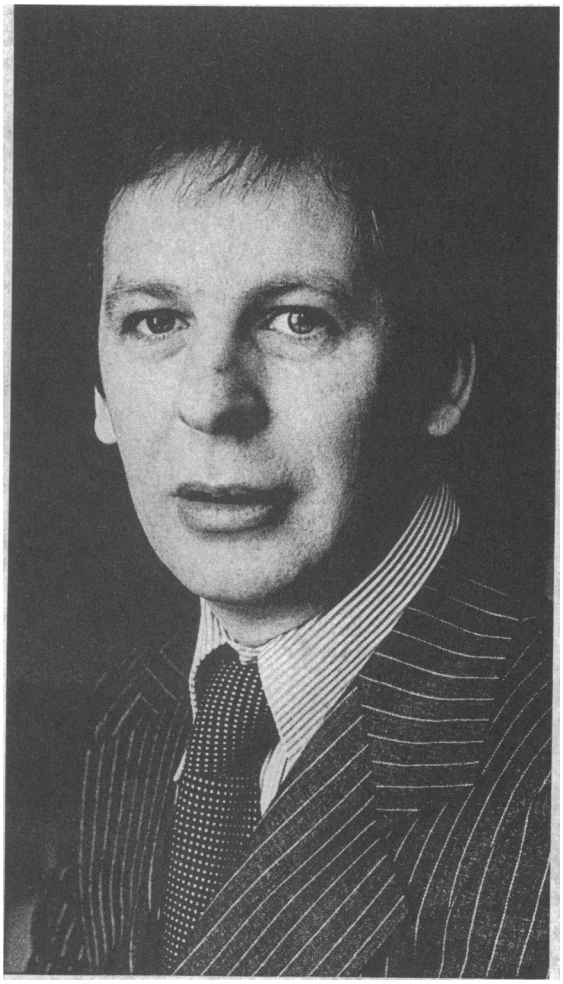
The council grew out of a bargain struck between doctors and the government in the middle of the last century.[19] The Medical Act of 1858 was passed after years of attempts by doctors to gain state recognition for their "profession." The doctors won for themselves protection against competition from other "unqualified" healers," and members of the public gained assurance that they would receive an acceptable standard of treatment if they attended a registered doctor.

To set about regulating the profession the GMC had to establish a register. As the Merrison report said, "the maintenance of a register of the competent is fundamental to the regulation of a profession." "Any such register," the report continued, "if it is not to be a fraud on the public must list only those having a certain standard of competence. The body maintaining the register has therefore two duties to discharge. First it will have to assure itself that those admitted to the register are competent. Secondly it will have to remove those practitioners unfit to practise." The two central concerns of the GMC are thus approving undergraduate medical education and qualifying exams—to ensure that registered doctors are competent—and removing from the register those who are not.

Limited progress

But even with these central concerns the council has made only limited progress in its 131 years. It has had to fight long and hard to gain power over undergraduate education, and it still has only limited control over postgraduate and continuing education. This limited control matters much more in an age when everybody recognises that an undergraduate qualification is only a beginning: doctors are not adequately trained after they have completed their preregistration year.

The disciplinary procedures were little used in the early years of the council, mostly against doctors who had brought the profession into disrepute, particularly



Ian Kennedy

"The jury is still out on whether self regulation by doctors is adequate at the end of the 20th century."

those who had been charged by the courts. Until very recently there was truth in the common charge that the council was more concerned when doctors slept with their patients rather than killed them through incompetence. This has now ceased to be true, and in the past 10 years the council has begun to apply its disciplinary machinery to doctors whose standard of practice has become unacceptably low. It does not, however, yet have any effective mechanism for weeding out and educating incompetent practitioners.

Doubt on self regulation

The council cannot thus guarantee to the public that everybody on the register is adequately trained and still competent. Whether a state run, predominantly lay body could produce such a guarantee is, however, questionable.

Ian Kennedy, a professor of law and medical ethics who sits on the GMC as a lay member and is a trenchant critic of medical practices,[20] thinks that more evidence is needed before it can be said that self regulation of doctors will be adequate at the end of the twentieth century. He quotes, however, pieces of evidence that make him think that self regulation needs to be looked at closely.

Firstly, the council has a primary duty to protect the public interest but has no efficient mechanism for asking the public what that interest is. The lay members clearly represent the public interest, but they exist in a vacuum. They are not elected and have no constituency; rather they are appointed for undefined reasons by the Privy Council. In contrast, more than half of the members of the council are doctors who are elected, many of them sponsored by the BMA. Secondly, Professor Kennedy worries about the accountability of the council, which is not to parliament but rather to the Privy Council. Also the media—which he says "are the ultimate court in Britain"—are kept at a distance by the GMC. Thirdly, he is concerned that the council is not seen to secure the public interest: too many complaints are dismissed without lay involvement and without open examination and public scrutiny. Fourthly, he is worried that the argument over the extent of the GMC's disciplinary role—what complaints it should deal with—is "resource led"—that is, that one of the main arguments of the GMC for not tackling more complaints is that it doesn't have the resources.

Professor Kennedy would like to see a much more proactive GMC that insisted on regular reregistration and included some sort of inspectorate. This inspectorate should be able to look at anything—including issues like communication with patients and ethics—and it would need specific guidelines on what constituted good practice. Many doctors would argue that such guidelines would be impossible to produce because so much of medicine is inexact; furthermore, their production would consume enormous amounts of time and skill, and they might lead to a very restricted and defensive style of practice. Professor Kennedy argues that such guidelines could be produced and that they must already exist in a non-explicit form so that the disciplinary committees can make their judgments.

Conclusion

The route suggested by Professor Kennedy is just one way that the GMC might be reformed, but I discuss it here to provide a sketch of radical reform. The rest of the articles in this series will look in detail at the work of the GMC, and much of the discussion will be over minor reforms that might be made. But it is important to bear in mind that the whole GMC might be swept away and replaced with a different body.

1 Robinson J. *A patient voice at the GMC. A lay member's view of the General Medical Council.* London: Health Rights, 1988.
2 Rosenthal MM. *Dealing with medical malpractice: the British and Swedish experience.* London: Tavistock, 1987.
3 Committee of inquiry into the Regulation of the Medical Profession. *Report.* London: HMSO, 1975. (Cmnd 6018.) (Merrison report.)
4 Green D. *Which doctor? A critical analysis of the professional barriers to competition in health care.* London: Institute of Economic Affairs, 1985.
5 Ham C, Dingwall, R, Fenn P, Harris D. *Medical negligence; compensation and accountability.* London: King's Fund Institute, 1988.
6 Anonymous. GMC strengthens professional conduct procedure. *Br Med J* 1984;**289**:1325.
7 O'Donnell M. *BMA News Review* 1986; Sept: 41.
8 Stacey M. A sociologist looks at the GMC. *Lancet* 1989;i:713-4.
9 Crisp AH. Medical education. In: *Annual report 1986.* London: GMC, 1987.
10 Smith R. Doctors, unethical treatments, and covering up. *Br Med J* 1989;**298**:1125-6.
11 Monopolies and Mergers Commission. *Services of medical practitioners.* London: Monopolies and Mergers Commission, 1989.
12 McManus IC, Wakeford RE. A core medical curriculum. *Br Med J* 1989; **298**:1051.
13 General Medical Council. *Recommendations on basic medical education.* London: GMC, 1980.
14 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients.* London: HMSO, 1989. (Cmnd 555.)
15 Warnock M. A national ethics committee. *Br Med J* 1988;**297**:1626-7.
16 Dahrendorf R. In defence of the English professions. *J R Soc Med* 1984;77:178-85.
17 Varlaam CF. The origins and development of the GMC as a sociolegal institution. [PhD Dissertation]. London: University of London, 1978.
18 Stacey M. The General Medical Council and professional accountability. *Public Policy and Administration* 1989;**4**:12-27.
19 Pyke-Lees W. Centenary of the General Medical Council 1858-1958. In: *The history and present work of the council.* London: General Medical Council, 1958.
20 Kennedy I. The *unmasking of medicine.* London: Allen and Unwin, 1981.
21 Hailsham Lord. How to ruin the professions. *Spectator* 1988;March 26:17-8.