Discipline I: the hordes at the gates

Richard Smith

To be found guilty of serious professional misconduct is dreadful for any doctor. It is also a chilling moment when one doctor watches another being found guilty of the charge. On the morning of Monday 6 March I sat in the public gallery at the General Medical Council and watched as Dr James Mills was found guilty of serious professional misconduct. The gravity of the moment stuck terror into me, and for a moment I was in awe of the profession of which I am an unconventional part. This effect is intended. One of the reasons for finding doctors guilty of serious professional misconduct is to keep other doctors in line. But to appreciate the huge anxiety that surrounds the charge is to begin to understand why the GMC sometimes seems so remote and such an anachronism.

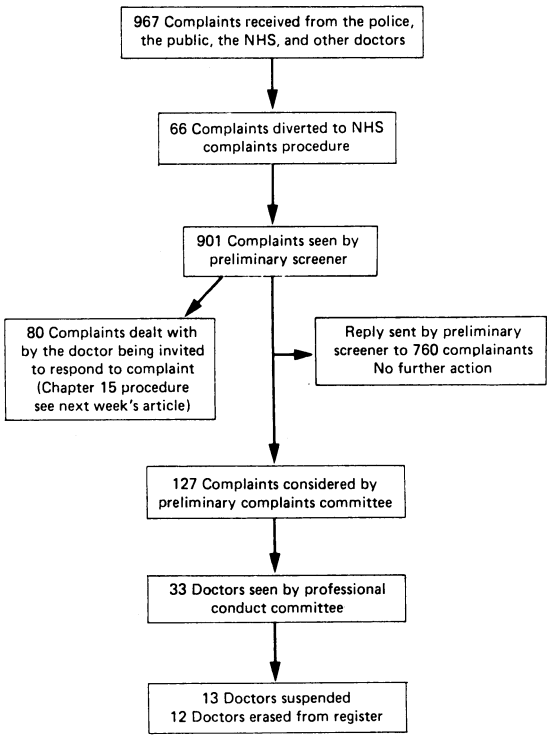
At the moment it is the disciplinary activities of the GMC that give rise to the most publicity and controversy. Member of parliament Nigel Spearing has several times tabled a bill trying to force the council to accept a lesser charge than serious professional misconduct, and he does not intend to give up.[1,2] He argues that the GMC being able to charge doctors only with serious professional misconduct is like a court being able to charge people only with murder and not with manslaughter. Jean Robinson, a lay member of the GMC, has greatly displeased some of the council[3] by publishing a report on what she sees as serious shortcomings in its disciplinary procedures.[4] Maryon Rosthenthal, an American sociologist, argues in a book that the council is not taking on as many cases as it should because of limited resources.[5] The BMA has meanwhile tried to reduce the number of cases being referred to the GMC from medical service committee hearings, and Dr Michael O'Donnell, a longstanding member of the council, has argued that the council's methods of responding to incompetent doctors are inadequate and need improvement.[6]

These criticisms, particularly those of Michael O'Donnell, have encouraged the council to set up a working party to examine alleged neglect or disregard of professional responsibility. The report is due this month but is expected to keep to the party line that it would be wrong for the GMC to take on many more cases. The council believes that these complaints are much better dealt with locally.

Overall structure of complaints machinery

The council has a four stage process for dealing with complaints (figure), and they are described somewhat baldly in the "blue book," *Professional Conduct and Discipline: Fitness to Practise.*[7] The book also defines serious professional misconduct, gives some guidance on what may be deemed to be serious professional misconduct, and offers general advice on professional conduct. The council follows the book very closely in deciding cases. The statutory requirements on the council limit its ability to make flexible responses: it must work by the book.

The complaints referred to the council are first seen by the council staff. Most are passed swiftly to the preliminary screener, a senior member of the council, often the president, who concludes many of the complaints—sometimes with help from members of the preliminary proceedings committee. Those that are the result of convictions or that raise in the mind of the preliminary screener a question of serious professional misconduct are referred to the preliminary proceedings committee. The committee concludes many cases but refers to the professional conduct committee the cases that may well be of serious professional misconduct. This committee, which conducts its hearings in public and with most of the panoply of law, is the highest disciplinary committee of the council. Appeals against its decisions are heard by the judicial committee of the Privy Council.



In parallel with this disciplinary process the GMC now has a health committee, which deals with doctors whose fitness to practise is seriously impaired by illness. Doctors may be diverted from the disciplinary procedure to the health committee by the preliminary screener or by either of the two committees.

Sources of complaint

The GMC receives about 1100 complaints a year from four main sources: the police (70 cases), the NHS (50), doctors (200), and the public (800). This number has remained fairly constant, which is somewhat surprising when complaints about the NHS, complaints to the ombudsman, and legal actions against doctors have all increased. That complaints to the GMC have not increased may reflect a lack of public confidence in it, but nobody can be sure.

COMPLAINTS FROM THE POLICE

Since its foundation the GMC has been informed automatically of convictions in the courts against doctors. The system seems to work efficiently, although there may be some variation among police authorities.

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All but the most minor offences (for instance, motoring offences) are referred automatically to the preliminary proceedings committee (including a conviction against a doctor for neglecting the hooves of his Shetland pony).

COMPLAINTS FROM THE NHS

Referrals from the NHS are much more erratic; there are longstanding criticisms that complaints against general practitioners are much more likely to result in referrals to the council than those against hospital doctors. In an average year the council receives about 40 referrals from medical service committee hearings, which deal with alleged breaches by general practitioners of their terms of service, and 10 from hospitals. This might reflect the fact that more than 90% of consultations with doctors take place in general practice, that the hospital system has a wider range of options for dealing with complaints, that the general practice complaints system is more rigorous, or that complaints against junior doctors are more likely to be dealt with locally.

These are, however all hypotheses (or even excuses), and the GMC is concerned about the lower rate of referrals from hospitals. It has thus encouraged regional medical officers to refer cases to it, but the system does not work efficiently. Interestingly, the council has begun to receive referrals from regional and district managers. One reason may be that managers (many of whom have come from industry and commerce) see complaints not as a source of disquiet but rather as means of improving the service.

Referrals from medical service committee hearings may occur routinely simply because the system is centralised—unlike hospital complaints. The committees forward all cases to the relevant secretary of state, and they are all considered by medical advisory committees. Not all findings against the general practitioner are referred to the council, nor—in contrast to popular belief—are all complaints referred in which more than a certain amount of the doctor's remuneration is withheld. The criteria for referral have been in force since the beginning of the NHS and are complicated. The council is currently negotiating with the departments of health to revise the criteria.

COMPLAINTS FROM DOCTORS

Each year the GMC receives about 100 complaints from doctors about other doctors. Most concern advertising, canvassing, or disparagement. The rules on advertising will probably have to be altered after the recent report from the Monopolies and Mergers Commission, which recommended that in some circumstances doctors should not be stopped from advertising.[8]

There is also pressure to change the guidance on disparaging other doctors. The fact that doctors are specifically told that disparaging colleagues may amount to professional misconduct has long caused disquiet among some members of the public,[3 9 10] who worry that this may stop doctors complaining about colleagues who are incompetent or are practising unethically—recently attention has focused on a case in which there was a long delay in taking action on a doctor selling untested treatments for AIDS and cancer.[9 11] The response of the council to this charge is to point out that the blue book places a duty on doctors to "inform an appropriate body about a professional colleagues whose behaviour may have raised a question of serious professional misconduct." But doctors have been found guilty of serious professional misconduct for disparaging other doctors whereas there seem to be no examples of doctors being disciplined for failing to act.

Most of the complaints received by the GMC from doctors are referred to the preliminary screener, but few progress as far as the full professional conduct committee. Advertising, in particular, is usually inadvertent, and a warning to offending doctors to be more careful in their relations with the media usually ends the matter.

About 100 doctors a year also write to the council asking for advice on particular matters. If the council has established rulings on the matter the doctor will be pointed towards the relevant section in the blue book. If the council has not ruled on the matter then the preliminary screener may offer a personal opinion. Alternatively, the matter may be thought important enough to refer to the committee on standards of professional conduct and medical ethics for a ruling. The doctor may also be referred to the defence societies, the BMA, or other sources of guidance.

The staff of the GMC are anxious about making pronouncements on what is and what is not acceptable because the council is the body that will have to make a judgment if a complaint is made about the matter. This has a legal logic but is frustrating for doctors trying to find out what they can and cannot do. Members of the public are also sometimes annoyed that they cannot get a straight answer on what is acceptable and what is not. But it is hard to see how this problem can be circumvented.

COMPLAINTS FROM THE PUBLIC

Almost every day the GMC receives complaints from members of the public against doctors. Usually these come as letters; people making a complaint by telephone are asked to put it in writing. Complainants may be directed to community health councils for help with preparing their complaints. Most complaints are seen by the preliminary screener, but those that concern medical treatment from an NHS doctor are dealt with by the staff of the council.

These complainants are directed to the statutory NHS complaints machinery, given the name and address of the person they should complain to, and told to proceed quickly because of the time limit on complaints. The complainants are also told that they may continue with their complaint to the GMC rather than to the NHS if they choose and that they may bring their complaint back to the GMC after it has been dealt with by the NHS machinery, whatever the outcome. The only available data show that between 1 September 1986 and 31 August 1987 the council received 832 complaints from the public and that 178 were diverted to the NHS in this way.[12]

Diverting cases to the NHS complaints machinery

The way that the staff of the GMC divert complaints about medical treatment to the NHS upsets Mrs Robinson, members of community health councils, and other health pressure groups.[3] They regard this diversion as contrary to the statutory instrument approved by parliament, which requires the GMC to consider complaints about conduct or fitness to practise. The process of diversion is not written into the Medical Act but is the result of custom, dating back to when Lord Cohen was president of the council in 1973. The council has four main arguments for adopting this approach.

Firstly, it believes that such complaints are better dealt with locally, where doctors, patients, and authorities know each other; there is then a chance that the case may be settled amicably and speedily, particularly if the authority operates a system of getting the complainant and the doctor together for informal conciliation. Local health authorities can also deal with cases that include nurses and other staff (the GMC can discipline only doctors) and health authorities also

have the resources to make changes as a result of their decisions. Further, the NHS system—unlike the GMC system—has a time limit; patients can thus have their case heard within the NHS and then if they wish return to the GMC.

Secondly, it feels that its job is not to settle all differences between patients and doctors. The annual report for 1987 says: "The council's disciplinary procedures are not designed to be a means of disciplining all doctors who have made mistakes or behaved badly. Their function is to protect the public and to maintain the reputation of the profession upon which good medical practice depends."[12] NHS authorities, the council points out, have a statutory duty to investigate complaints about medical care and treatment whereas this is not a function specifically assigned to the GMC in the Medical Act 1978.

Thirdly, investigating the complaint at the same time that it is processed through the NHS machinery is simply not possible as the various groups would be competing for the notes and other documents.

Fourthly, if the council were to accept all these cases at once it might be overwhelmed, needing more staff and resources and the funds would have to come from doctors. Doctors will pay so much for the privilege of self regulation but would probably be unwilling to pay the several hundred pounds a year that might be required for a more intensive and extensive disciplinary system. This argument is not used much publicly but may be the most important to the council.

Problems with the GMC approach

One substantial problem with the GMC's approach to disciplinary cases is that it relies on the quality of the NHS complaints machinery. Yet the machinery is seen widely—for instance, by community health councils and Action for the Victims of Medical Accidents—as poor and biased towards doctors. There are also anxieties about geographical variation in the quality of justice dispensed through the NHS complaints machinery. The GMC may thus be seen to be failing in its primary duty to serve the public by diverting complainants to what is thought to be inadequate machinery. The new systems recently introduced in the hospital service may be perceived by the public as an improvement, but Sir John Walton, past president of the GMC, pointed out to me that an important defect is their lack of lay involvement.

A second difficulty with diverting cases to the NHS was mentioned to me by Ian Kennedy, a professor of law and a lay member of the council. His worry is that medical service committee hearings are concerned with breaches of terms and conditions of service whereas the GMC is concerned with serious professional misconduct: the two charges are different.

A third problem is delay, which may amount to years. If a doctor has committed serious professional misconduct and should be removed from the register in the cause of public safety it seems wrong for the doctor to remain on the register while the complaint makes its way through the NHS procedure. Similarly, if the complaint has arisen because the doctor has a health problem it would be both safer and more humane to put him or her in the care of the health committee. The GMC has the power to do this and will sometimes act quickly in response to complaints that show clearly that a doctor's health is seriously impaired, thus endangering his or her patients.

A final problem with this policy is that it may fail to recognise the vulnerability of some of those making complaints. If you screw up your courage to write to the GMC it may be very discouraging to be told promptly that you must take your complaint elsewhere. If a primary concern of the GMC is to guarantee to the

The case of Alfie Winn

Alfie Winn, an 8 year old boy who was the official mascot of West Ham Football Club, died of meningitis in January 1982. His mother argued that he had not been cared for adequately by his general practitioner, and it is his case that has inspired his member of parliament, Nigel Spearing, to take up a campaign to oblige the General Medical Council to introduce a lesser charge than serious professional misconduct.

STEVE BACON

Alfie Winn

Mrs Maureen Winn, Alfie's mother, called Dr Oliver Archer to see her son one morning when he had a high temperature and was comatose. Dr Archer arrived after three hours and asked Alfie to open his mouth. "He can't hear you," said Mrs Winn. "If he cannot be bothered to open his bloody mouth I shall not bloody well look in," answered Dr Archer, who diagnosed a respiratory infection, prescribed some antibiotics, and left. Two hours later the family called an ambulance, and Alfie was admitted to hospital, where he died four days later.

In July 1982 the City and East London Family Practitioner Committee censured Dr Archer and stopped £1000 from his remuneration. The Secretary of State referred the case to the General Medical Council, which decided that Dr Archer was not guilty of serious professional misconduct. Mrs Winn was so incensed by the decision that she twice assaulted Dr Archer, and later her daughter assaulted his partner and receptionist. Both were charged and appeared in court.

In 1984 Dr Archer reappeared before the GMC. In October 1982 he had been called to see a woman who was having a miscarriage. Dr Archer told her to push the baby out, wrap it in newspaper, and flush it down the lavatory; she should then come and see him three days later. Before that happened the woman was admitted to hospital. This time the professional conduct committee of the GMC found Dr Archer guilty of serious professional misconduct, and he was referred to the health committee.

Mr Spearing is determined to persist with his parliamentary attempts to revise the Medical Act. His very short amendment reads: "Where a fully registered person is judged by the professional conduct committee to have behaved in a manner which cannot be regarded as acceptable professional conduct the committee may, if they think fit, direct that the registration shall be made conditional . . ."

public the competence of doctors on its register the council should welcome complaints—because they provide one important means of detecting those doctors who are not competent.

LEGAL CHALLENGE TO THE GMC POLICY ON DIVERTING COMPLAINTS?

Because the council's policy of diverting complaints on medical treatment to the NHS is not written into the medical act it may be possible to challenge the policy in the courts—and win. This has not yet been tried.

Conclusion

This article has described what Mrs Robinson called "the first hurdle" in the GMC complaints machinery.[3] Three are still to come—the preliminary screener, the preliminary proceedings committee, and the professional conduct committee. These will be described in the next article; it is not difficult to understand why Mrs Robinson and others use the image of hurdles; to reach the finishing post of serious professional misconduct is exhausting for both patients and doctors.

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How To Do It

Be a manager

Cyril Chantler

There is no right or wrong way to learn how to be a manager, and in this respect management is quite different from medicine or science. My qualification for being asked to write this article is that I spent three years as chairman of our hospital board of management, with the title of unit general manager but without any specific training apart from reading a book while on a long journey before taking up my appointment.[1] I have read two other books since[2,3]; Sir John Harvey Jones's *Making it Happen* I recommend to any clinician or academic because it emphasises the importance of leadership with its characteristics of imagination, courage, and sensitivity. Management is not the same as command or administration, but it requires characteristics derived from both. I am concerned mostly with the contribution that clinicians can make to the success of the NHS.

Qualifications

Many doctors have management experience, though they commonly discount this and spend little time analysing it. Most will have been required to organise activities on behalf of others at school, at university, or in practice. They are also experienced at making difficult decisions with inadequate information. They learn to live with the consequences while being prepared to accept that when they are wrong they must try again, driven by their responsibility for other people's lives and health. Sometimes they find it difficult to accept that management, like medicine, is an inexact science. At least as far as hospitals are concerned, management is important because doctors can serve their patients only if the resources are available and the whole team is organised to work at maximum efficiency.

Clinicians are natural leaders in a hospital. They, more than any other group, make the decisions that most affect the activities of the whole organisation. Consultants are usually associated intimately with a single hospital over many years. They are well educated and intelligent (intelligence being a necessary criterion for entry to the profession) and undoubtedly develop stamina in the early years after qualification. A sense of humour, if not natural, is certainly a common defence against the tensions of the job. All of these characteristics are useful for a manager. Doctors and managers ought to be good listeners: attentive listening is essential for obtaining a clinical history from a patient, which enables the nature of a problem to be defined clearly in a relatively brief time. Doctors concerned with management are, surprisingly, not always as skilled as might be expected at counselling staff and making decisions that may affect employees profoundly. Sometimes a natural loyalty to people hampers decisions that are vital to a hospital. It is no use keeping people in jobs that are not necessary or in which their performance is poor; it is far better to help them by analysing their performance, providing motivation, retraining them, or occasionally allowing them to leave with proper entitlements.

Strategy and structure

It is always worth spending a great deal of time thinking and talking about the strategy of the organisation and making sure the structure is, or remains, correct. In 1984 Guy's Hospital was faced with a reduction in its budget of nearly 20% over eight years. The previous five years had been characterised by closures of beds, inadequate replacement of equipment, little expenditure on the infrastructure of the hospital, and falling morale with increasing antagonism between different professional groups. Consultant staff, angered by their inability to provide care and by problems ranging from lengthening waiting lists to the frequent absence of outpatients' records, made formal representations at all levels of the health service, and many of us took advantage of the proximity of Guy's Hospital to Fleet Street and the media to appeal to the public for more money for the hospital, but with little success. One consultant, however, succeeded in securing a donation to sustain his service for a year, and another set up an appeal fund that has provided over £250 000 yearly in revenue to support the children's unit.

The crisis encouraged a deep analysis of strategy and structure. The most important question to be

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