BMJ

LONDON, SATURDAY 16 MAY 1992

The GMC on performance

Professional self regulation is on the line

Time may be running out for the General Medical Council (GMC). Well into its second century, it is trying to come up with a system for dealing with doctors who consistently perform poorly. Next week it meets to debate a formal consultation paper that will then be widely circulated before the council proposes the legislation that will be necessary to implement the system. The ideas have been several years in the making and are at least three to four years from implementation. The risk to the council is that it fails to produce a system that satisfies both doctors and the public or that its painfully slow processes are overtaken by speedier events—like a scandalous case or a political campaign to substitute self regulation with regulation by the state.

The ways of the GMC are a mystery not only to most members of the public but also to most doctors. It is a misunderstood organisation. But its reason for existence is actually straightforward: it maintains the medical register and attempts to guarantee to members of the public that everybody on that register will treat them professionally. From this central duty flow the council's primary tasks of inspecting the education of all those admitted to the register and removing from the register all those who fall below acceptable standards.

In its early days the council concentrated on removing the unqualified from its register, supporting the suspicion that it might in reality be more interested in protecting the monopoly of doctors than the public, but eventually it developed machinery for deregistering doctors guilty of serious offences.[1-3] The commonly heard criticism that the council was more concerned with doctors who slept with their patients rather than killed them through incompetence ceased to be true about 10 years ago, and doctors are now removed from the register for outrageous acts of incompetence. And in 1980—after many years of debate—the council introduced a system for dealing with doctors who performed poorly because of sickness. This system has been widely regarded as successful, and the proposed system for dealing with doctors who consistently perform badly is based on it.

There is longstanding unhappiness with the council's seeming inability to respond to doctors who are incompetent or rude but who have not been guilty of an act that the council would judge to be serious professional misconduct.[4] A member of parliament, Nigel Spearing, introduced a bill that would have obliged the council to produce a lesser charge than serious professional misconduct.[5] Various patients' organisations have doubted that self regulation can ever be in the public interest, and at least one television programme has presented its audience with a series of what looked like open and shut cases of incompetence and yet in which the council took no action.[6]

One particular case haunts the council rather in the way that the Steve Biko case haunted the Medical Association of South Africa, and whenever the case of the 8 year old Alfie Winn is mentioned members of the council wince. Despite that, the case is worth repeating because it is the grossest illustration of why the council needs new machinery. Alfie died of meningitis in 1982 after his doctor, Oliver Archer, took three hours to go and see him and then failed to have him admitted to hospital. Alfie couldn't open his mouth because he was semicomatose, but Dr Archer told his mother, "If he can't be bothered to open his bloody mouth I shall not be bothered to bloody well look in." The GMC decided that Dr Archer was not guilty of serious professional misconduct, but two years later he was referred to the health committee after telling a woman who had had a miscarriage to wrap the fetus in newspaper and flush it down the lavatory. Dr Archer's case arose in Mr Spearing's constituency and inspired him to introduce his bill.

The essence of the new machinery is that it will deal with long term poor performance before it leads to spectacular episodes that might invoke the disciplinary machinery. The aim will be to help and encourage failing doctors to take remedial action that will restore them to high quality practice. The council hopes that audit mechanisms and local professional and managerial action will deal with most cases in which doctors' standards begin to slip: the council will become involved only when these local systems fail. Even then local assessment will be used by the council. The central machinery will, it is hoped, be used only rarely and for intransigent cases.

The new machinery will thus be a back up for NHS systems. The best strategy for raising quality in the health service is to concentrate on raising performance right through the service rather than on weeding out those who perform badly.[7,8] It is also wise to concentrate on systems rather than individual people. But there is no escape from having some mechanism for dealing with those who slip below acceptable standards, and local NHS procedures are not enough: they do not cover doctors who work outside the NHS and are widely perceived by consumers to be inadequate. The GMC thus has to develop a new system, but there will be problems.

Firstly, poor performance among doctors may be more

common than the council expects. Nobody has ever attempted an examination of the performance of a random sample of doctors in Britain, but such surveys have been done in Canada and found serious deficiencies in between 8% and 15% of almost 900 family doctors and 2% of 380 specialists (R G McAuley, congress on continuing medical education, Los Angeles, 1988).[9] Then a study of 31 000 random admissions to hospital in New York in 1984 showed that 4% led to adverse events, and in a quarter of those cases the doctors had been negligent.[10] In Britain the first confidential enquiry into perioperative deaths found that 7% of the deaths were solely attributable to surgery and in many more surgical and anaesthetic problems partially accounted for the deaths.[11] These pieces of information suggest that poor performance may not be rare and that the GMC machinery may need to have extra capacity built in "just in case."

The second important problem is the relation between the new machinery and audit. It is probably no accident that government pressure for audit and public pressure for more accountability from the GMC have come together, but the timing is unfortunate. Most doctors agree that if audit is seen as an antechamber to the GMC's performance review machinery then audit will not flourish. But inevitably local attempts to manage those who will not participate in audit or who are unwilling or unable to improve poor performance exposed by audit may eventually become entangled with the GMC system. This is something that doctors don't like to contemplate, but they will have to.

The third problem lies in the nature of poor performance. The GMC's proposal talks in terms of retraining those doctors who perform poorly, but managers from any walk of life know that poor performance is rarely managed by a short spell of retraining. Poor performance often has its roots in a combination of psychology and circumstance that is not so easily reversed. Thus some of those entering the GMC machinery may need prolonged retraining that may not succeed, and they may face loss of livelihood. The difficulty and expense of getting poor performers back on track may mean that cash strapped health authorities will be unwilling to foot the bill. They may choose the cheaper option of dismissal, leaving the council to pick up the bill or deregister the doctor.

And the fourth problem is expense. Doctors are willing to pay for the privilege of self regulation, but they will not be willing to sign a blank cheque. The finances of the GMC are already shaky because of the rapidly rising cost of cases of possible misconduct, and the annual retention fee, which was introduced only in 1970, has more than doubled in the past two years. Now the cost of the new machinery must be added, which is difficult to cost. The president of the GMC told the BMA's council that he hoped that the system would add only about £5-10 a year to the annual retention fee (currently £80), but this estimate is based on the assumption that the NHS will pick up the costs of retraining. This is doubtful in all cases, and there is still the problem of doctors working as long term locums and those working in private practice. Predicting how many doctors will come through the system is also extremely difficult. The costs may be much higher than predicted.

Most doctors, even if they know little of the GMC, believe in self regulation, and we must hope that the GMC can produce a system that will help doctors who fall below acceptable standards without creating a climate of fear that will interfere with raising quality throughout the NHS. This must also be achieved speedily at an affordable price. None of it will be easy.

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Doctors, patients, and HIV

The risk of transmission from a single inoculation injury with HIV positive blood is 1:275

Recent reports of an HIV infected surgeon working in a British hospital have stirred up anxieties about the transmission of HIV from patients to doctors and from doctors to patients. This week's report from the Royal College of Pathologists should go some way to allay them. *HIV Infection: Hazards of Transmission to Patients and Health Care Workers during Invasive Procedures* provides up to date information on transmission of HIV from patients to staff.[1]

During a surgical operation or resuscitation of a critically ill patient the thoughts of the operator are usually focused on the task in hand. Unless there has been a reason to suspect infection in the patient the possibility of exposure to HIV and other bloodborne viruses may not be prominent in the minds of the surgeons, dentists, anaesthetists, or other staff participating in the procedure. Clearly the best approach to preventing occupational infection is to regard blood from any patient as potentially infectious and to adopt "universal precautions" with all patients so that the risk of inoculation injury or mucocutaneous exposure is removed or at least reduced to a minimum. Despite the concern generated by the spread of HIV infection these incidents occur frequently and are a continuing source of anxiety.

After such incidents health care workers should seek confidential advice and, if necessary, medical follow up and serological testing. Responsibility for these services varies and usually rests with the occupational health service, clinical microbiologists, or virologists. Medical advisers need access to the latest data on occupational transmission and to be able to discuss difficult decisions such as the prophylactic use of zidovudine. The royal college's recent report should help them. Its statistics, which will be updated as necessary, are accompanied by recommendations for reducing risk and an extensive list of references.

Before the recent British case the potential hazards posed to patients from surgeons and dentists infected with HIV-1 came under scrutiny after reports suggested that five patients had been infected through invasive dental procedures performed