

“All patients are entitled to good standards of practice
and care from their doctors.” Professor Sir Graeme Catto President, GMC

GENERAL
MEDICAL
COUNCIL

*Protecting patients,
guiding doctors*

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“Revalidation, and the rigorous processes that precede revalidation, are perhaps the most sure ways of maintaining public confidence in professional regulation and its ability to protect patients; and above all to maintain the trust on which sound relationships between patients and their doctors depend.” **Professor Carol M Black** President, Royal College of Physicians of London



“The phrase ‘Trust me I’m a doctor’ belongs to a bygone age. A new balance is being struck between informed and engaged patients and their doctors. Patients deserve and are demanding new systems of clinical governance and evaluation to ensure that what can be done is done to protect patient safety.”

Paul Burstow MP, Liberal Democrat Health Spokesman

Our role and values

The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Our vision To be recognised as delivering and safeguarding the highest standards of medical ethics, education and practice, in the interests of patients, public and the profession.

The GMC has powers to permit doctors to practise, and to remove or restrict the right to practise if they fail to meet the standards it has set. Its powers apply to both the NHS and the private sector throughout the UK.

Many different organisations contribute to providing and assuring the quality of healthcare in the UK. However, the GMC has a distinctive role in ensuring that doctors are professionally competent and they treat patients and colleagues in a way that upholds the principles of good medical practice.

The GMC is an independent body and represents a partnership between the public and the profession. This concept of 'professionally-led regulation in partnership with the public' enables the GMC to set a framework of standards and ethics that is owned by the profession while reflecting the views and expectations of the public. The values are embodied in the publication *Good Medical Practice*, which underpins all the GMC's work.

The GMC is uniquely placed to lead the debate on the principles of good medical practice. It is also solely responsible for setting and monitoring standards for undergraduate medical education, and for co-ordinating all stages of medical education.

The GMC's statutory purpose is 'to protect, promote and maintain the health and safety of the public'. The same statute defines the GMC's functions, which are:

- defining the standards and ethics that society and the profession expect doctors to follow throughout their working lives;
- encouraging high quality training of new doctors in the UK and co-ordinating all stages of medical education;
- registering and licensing doctors for practice in the UK; and
- dealing firmly and fairly with doctors whose fitness to practise is questioned.



President's foreword

From asylum-seeker doctors to organ retention and from patient confidentiality to the Shipman Inquiry, the backdrop to the GMC's reforms is one of major issues affecting society.

A glance at the news headlines of 2003 throws into sharp relief the changing landscape faced by the GMC and the whole of the medical profession today. From asylum-seeker doctors to organ retention and from patient confidentiality to the Shipman Inquiry, the backdrop to the GMC's reforms is one of major issues affecting society.

The GMC believes that professionally-led regulation in partnership with the public offers the best way to encourage high standards of medical practice, protect patients and be responsive to change. That is why the reforms, described in this annual review, represent such an important milestone. The reformed Council, which met for the first time in July 2003, is a visible demonstration of the GMC's determination to be fit for purpose. With a far higher proportion of lay members, the slimmed-down Council is already demonstrating the benefits of greater public involvement and the ability of the public and the profession to work together.

Partnership with the public keeps us in tune with the concerns and priorities of contemporary society and ensures that standards are upheld for the benefit of all. It balances the need for doctors to have ownership of their own standards and ethics with the needs and wishes of patients. It supports doctors through education and clear guidance at every stage of their career, working closely with the education sector. We believe the new system of a licence to practise and periodic revalidation, which will be introduced in 2005, will reinforce public confidence in the profession.

Upholding standards for all doctors is a far more ambitious goal than merely disciplining the tiny minority of dysfunctional doctors, the issue that inevitably tends to dominate media headlines. Through raising the quality of regulation we can protect the public while removing unnecessary barriers to the recruitment of the doctors we need, from the UK and all over the world – including suitably qualified doctors who may be refugees or asylum seekers. In a year when the public profile of asylum seekers has never been higher, the GMC has put forward proposals to ease the financial burden of registration.

Putting regulation at the heart of clinical governance

'Clinical governance' is the system that protects patients by monitoring the standard and effectiveness of healthcare in the UK. The clinical governance system provides objective data across the medical profession, encompassing everything from surgical success rates to patterns of drug prescription by doctors. It is essential that the GMC should have access to this information so that we will no longer have to rely solely on data provided by doctors themselves. As clinical governance becomes more robust it will provide the essential independent verification we need on the quality of medical practice.

Regulation cannot operate in isolation, and that is why we place such a strong emphasis on partnerships with every part of the profession and society as a whole. Traditionally this has mainly been achieved through the local networks that deal with complaints about poorly performing doctors. In 2003 we forged closer links with patient groups through our own Patients Reference Group, and all parts of the healthcare profession in the UK, for example working closely with the UK departments of health in developing revalidation. Together, we have an important contribution to make to new legislation. We welcomed the opportunity to comment on the Health and Social Care Bill and the issues it raises about patient confidentiality. On the European stage the GMC has taken a leading role in the formation of AURE (the Alliance of UK Health Regulators on Europe).

We must constantly reflect the changes taking place in a society that is more complex, more heterogeneous and sometimes more violent. The guidance we issued on gun crime this year was welcomed by police and doctors. We strive to uphold equality of opportunity throughout the profession. An unresolved issue is the disproportionate number of overseas doctors who are referred to our procedures for complaints about doctors. We are investigating why this is happening.

Listening to the public

Every part of the profession has a responsibility to ensure that patients know where and how to complain when things go wrong. At present, the fact is that many people are baffled. Around 50% of complaints received by the GMC have to be redirected to other organisations. Closer co-ordination is needed to deal with the problem. During 2003, we proposed a new gateway for complaints about all aspects of healthcare in the UK. This does not mean setting up yet another organisation to deal with complaints – quite the reverse – but to guarantee that every one reaches the right place and is dealt with promptly and professionally.

The public inquiries taking place during the year demonstrate why it is so important to listen to the public. The GMC has already learned much from their scrutiny. Finlay Scott and I were grateful that some of the families of Harold Shipman's victims agreed to meet us. That they were disillusioned with the medical profession was hardly surprising. But they were also confused by the complexity of the relationships between the GMC, the NHS and general practitioners. We believe the gateway idea would help to remove confusion that has been heightened by the number of different healthcare organisations.

Every part of the profession has a responsibility to ensure that patients know where and how to complain when things go wrong.

The GMC and the medical profession as a whole owe it to those families to learn the lessons and implement the necessary changes. As our reforms gain momentum they will provide the framework to do that and raise standards for all patients. We are heartened by the support we have received from the public, profession, and politicians in the past year. I am confident that a GMC that is more professional, outward looking and proactive is well equipped to meet the challenges that lie ahead.



Professor Sir Graeme Catto



Review of 2003/4

By the end of 2003 we were well on the way to delivering the remaining elements of the reform programme designed to ensure that the GMC, and the services we provide, are up to date and fit for purpose.

In a year of many challenges, a key priority has been to develop and implement new procedures, while maintaining and improving existing services. By the end of 2003, we had met our operational objectives for the year; and were well on the way to delivering the remaining elements of the reform programme designed to ensure that the GMC, and the services we provide, are up to date and fit for purpose. In 2004, it will be vital to maintain the momentum and to sustain confidence in our determination to deliver what the public and the profession are entitled to expect – up to date, fully effective, medical regulation.

We registered record numbers of new doctors, around 60% of whom qualified outside the UK.

It was equally important to enable the reconstituted Council, our governing body, to hit the ground running. Council members, both continuing and new, quickly seized the challenge of implementing, and continuing to develop, the reform programme agreed with Government. Under the Council's leadership, the whole organisation is committed to making the reforms a reality and to transforming the GMC into a modern, outward looking, organisation with a clear sense of purpose – to protect, promote and maintain the health and safety of the public, by ensuring proper standards in the practice of medicine.

Improving standards

We raised standards of service in both our key operational areas – registration and fitness to practise. We registered record numbers of new doctors, around 60% of whom qualified outside the UK; and we introduced, and met, new operational targets for handling complaints against doctors.

A continuing priority has been to uphold and promote standards and ethics in practice and to support and encourage high quality medical education and training throughout doctors' careers. Our contributions to standards and ethics are highly respected in other countries. The quality and diversity of UK medical education, delivered through our partners in the universities and medical Royal Colleges, does immense credit to the UK.

Efficiency and effectiveness

We undertook a fundamental review of costs and identified opportunities to save in the order of £5 million each year. The relocation of work, from London to Manchester, will make a significant contribution to cost containment, as will the creation and expansion of our in-house legal services. We secured significant improvements in productivity, for example in registering record numbers of doctors without proportionate increases in costs.

There will continue to be upward pressures on our budget, with the implementation of reformed fitness to practise procedures later this year, the introduction of revalidation in 2005, and further licensing and registration reforms also in 2005. Despite these pressures, we are determined to postpone, and as far as possible avoid, increases in fees. The financial surplus from 2003 will enable us to defer any increase and to invest in ways that will reduce costs for the future.

What lies ahead

There remains much to do, for example to ensure greater consistency in the quality of our work; and to develop further our relationships with partner organisations. Meanwhile, past actions and decisions will continue to be scrutinised and, in some cases, justifiably criticised. There will continue to be tough questions.

We must listen carefully and learn lessons. Part of the challenge is persuading the public and the profession that the GMC of today should not be judged by the GMC of the past. We can be confident in the policies adopted by the Council and in our ability to complete the transformation on which we have embarked. The concept of professionally-led regulation, in partnership with the public, is at the heart of the changes now taking place.

Rightly, we will be judged by what we do rather than what we say – our actions will speak louder than our words.

A continuing priority has been to uphold and promote standards and ethics.

Far-reaching reform

We are engaged on the most ambitious reform programme since the GMC was established in 1858. The reforms have their roots in the 1995 legislation that enabled us to introduce new procedures for assessing doctors whose professional performance is in doubt. 1995 also saw the publication of the first edition of *Good Medical Practice*, which sets out the principles of competence, care and conduct expected of doctors in all aspects of their professional work.

The reconstituted Council was established on 1 July 2003. We have come a long way in the past 10 years, from a Council of 102 members, with 89 medical members and 13 public members. We now have a Council of 35, with 21 medical members and 14 public members. The substantially higher proportion of public members, increased from around 12% to 40%, reflects the determination of the Council and the profession to ensure that the concept of professionally-led regulation, in partnership with the public, is reflected in all aspects of our work.

Integrated fitness to practise procedures

By far the great majority of doctors deliver good quality healthcare, often in difficult and demanding situations. But a small proportion do not and concerns about their practice have to be investigated under our fitness to practise procedures.

Our existing procedures have developed piecemeal over decades and are no longer fit for purpose in today's conditions. In Autumn 2004, we will introduce reformed procedures, with the emphasis on prompt and effective investigation of serious concerns. We will make better use of local knowledge, through early contact with the doctor's employers once there has been a decision to investigate.

The result will be a more coherent, integrated, approach, that will be fairer to doctors, will increase satisfaction among complainants, and will make more effective use of resources. We plan to explain our decisions more clearly; and we will work with our partners to ensure that enquiries more appropriate to other bodies are redirected promptly. We want our procedures to be, and to be seen as, a properly integrated component of a wider system.

Making registration more coherent

At the end of 2003, we achieved long overdue simplification of the arrangements for registering international medical graduates. As a result, all doctors from outside the EEA are required to demonstrate their medical knowledge and skills at the point of first registration.

Each year, just over half of the doctors we register for the first time come from outside the UK. They make a vital contribution to the NHS. Many will have chosen the UK in preference to other options; and the GMC plays an important part in ensuring that they feel welcome here. We have a strong commitment to processes and procedures that are fair, objective, transparent and free from discrimination.

In the coming 12 months we deliver the next stages in the reform of our registration procedures, with the introduction of a licence to practise and the regular, evidence-based, revalidation of that licence.

Revalidation has three broad policy aims:

- to encourage all doctors to reflect meaningfully on their practice, using evidence gathered through audit and in other ways;
- to update what being registered and being qualified means, by shifting the emphasis away from qualifications alone, to being up to date and fit to practise; and
- to replace the 'management by exception' approach that has been in place since 1858, by introducing regular confirmation that there are no significant concerns about a doctor's practice and that the doctor is up to date and fit to practise.

Revalidation represents the most significant change to the regulation of the medical profession since the GMC was established in 1858. It is a massive and complex project, with implications for the more than 200,000 doctors registered with the GMC, for the NHS and other organisations, and, most crucially, for patients. Revalidation is a ground-breaking initiative that is being watched closely by other professions and by many other countries.

Europe

In the year 2003, 2,129 doctors from the European Economic Area registered with us for the first time. The need to respond to the proposed draft Directive on the mutual recognition of professional qualifications has led us to work very closely with other health regulators through the Alliance of UK Health Regulators on Europe. As a leading member of AURE, we fought hard to secure changes to the draft that, in our view, would have endangered public safety by weakening our ability to regulate effectively. We were encouraged by support from the UK Government and by the votes in the European Parliament, which accepted the amendments we had proposed.

Standards and ethics

The newly constituted Council quickly made it clear that it wanted the GMC's function to set the standards of good medical practice to be much more clearly understood by the public than it has been in the past.

We work in partnership with other organisations, with the public and with politicians in Westminster and the devolved legislatures in developing the guidance we provide for doctors and the standards we set. We worked closely, for example, with the Association of Chief Police Officers on the development of guidance on gunshot wounds. As we develop new guidance so we will continue to involve others and ensure that there is a full consultation process for all interested parties.

Education

The GMC has taken major strides in its role of promoting high standards in medical education. We have been piloting new arrangements for quality assuring medical schools and continuing to monitor the progress of the four new schools. The Chief Medical Officer for England has applauded our promotion of innovation in undergraduate medical education. We have been consulting on new proposals for the training of Pre-Registration House Officers and working with the competent authorities and health departments on the transformation of postgraduate education and training. We have issued guidance on Continuing Professional Development for the first time. And we are considering the huge changes that are likely in medical practice in the decades to come and their implications for medical education.

On the move

In 2002, the Council adopted two principles – that there should continue to be a significant GMC presence in London, and that there should be appropriate relocation of work from London.

By the end of 2003, we had relocated about 100 jobs from London to Manchester and this will rise to around 200 by the end of 2004. Our fitness to practice hearings are split equally between the two cities. Relocation of work will produce net savings, over 10 years, of around £15 million. It will also help to improve channels of communication with employers and others.

There has been a huge upheaval for London staff, many of whom will be leaving us. I am personally very grateful for their continued commitment and contribution during this time of change.

It is important for the GMC to recognise the realities of devolution. There are now four departments of health in the United Kingdom. In 2003 we opened an office in Edinburgh and the benefits are already clear. We are now planning to open an office in Cardiff later in 2004 and considering how to increase our activities and visibility in Northern Ireland.

Public inquiries

During 2003, the GMC gave evidence to public inquiries into the cases of three doctors – Clifford Ayling, Richard Neale and Harold Shipman.

The GMC of today should not be judged by the GMC of the past.

We are awaiting the final report of the Shipman Inquiry in the autumn of 2004. In the opening statement from our Counsel to the Shipman Inquiry we expressed our condolences and deepest sympathy for the families and friends of those who had been killed by Dr Shipman.

We made it clear to the Inquiry that the landscape of regulation of the medical profession has changed dramatically in the last 25 years. Indeed, it has changed beyond recognition since 1998 following reforms within the GMC and elsewhere. But when the report is published it will help us to review those changes and take further action if necessary. We are determined to discharge our statutory and charitable purpose, to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We believe that the reforms now being implemented and the introduction of revalidation in 2005 is crucial to the maintenance of trust between doctors and patients.

The pace of change

2003 was a year of profound challenge and change for the GMC. As a result, we are doing more, doing things better and doing different things.

The organisation is on a sound footing, with a clear-sighted Council providing strong leadership. We cannot wash our hands of past mistakes but we have learned from them and put new policies and procedures in place.

None of this would have been possible without the hard work and continuing commitment of my colleagues. I am grateful for their wholehearted contribution and for their determination to make the GMC fully fit for purpose in today's demanding conditions.



Finlay Scott, Chief Executive



“Parliament has given the GMC the tools to reform itself. It’s now up to the GMC to use these tools in discharging its important functions in a way that can command the confidence of the public.”

John Hutton MP, Minister of State for Health



“The public needs to feel safe and secure in the medical profession whilst accepting that over-regulation can be damaging to professionalism – a tricky conundrum.”

Professor David Haslam Chairman,
Royal College of General Practitioners



“The GMC must demonstrate to the public that it can deliver a package of reforms that meet the expectations of the modern patient, and convince them that the protection of the public is at the heart of all our activity.”

Michael Cotton GMC staff



“Revalidation is the bravest step that the medical profession has ever taken and is to be welcomed. It will lead to better, more up to date treatment and more trust and confidence from patients, carers and the public.”

Alan Hartley Ex-Chair,
ACHCEW and Member, Patients' Association

Moving forward

2003 – a year of reform The new, smaller Council will be able to act more quickly and effectively. It includes a higher proportion of lay members than before, giving the public a stronger voice.

Since May 2000, the GMC has been developing proposals to make it more effective, inclusive and accountable.

When Parliament approved the necessary legislation in 2002, it gave the green light for the most comprehensive and wide-ranging reform of medical regulation since the GMC was set up nearly 150 years ago. Putting the reforms into effect started in 2003.

There are three main areas of reform – the establishment of a new Council, a new complaints procedure and a new system of a licence to practice and revalidation for doctors.

The new streamlined Council

The Council is the GMC's governing body. Until 2003 it had 104 members and delegated much of its work, including the consideration of complaints against doctors, to numerous committees.

The new streamlined Council, which was established on 1 July 2003, consists of 35 members, 40% of whom are lay people. There are 19 elected medical members, two appointed medical members and 14 lay members appointed by the Government. The make-up of the new Council reflects the principle of professionally-led regulation in partnership with the public. It will meet seven times a year, more frequently than its predecessor.

The main reasons for the change are that the smaller Council will be able to act more quickly and effectively. It includes a higher proportion of lay members than before, giving the public a stronger voice. Under the new complaints procedure, Council members will no longer be responsible for case work, as in the past, but will be able to focus on governance of the GMC.

New fitness to practise procedures

The GMC has legal powers to act against problem doctors. At present, a decision must be taken at an early stage to stream a complaint into one of three separate procedures – health, performance or conduct. Each procedure potentially has different outcomes and not all can lead to being struck off the GMC's register.

New fitness to practise procedures are being introduced in 2004. All complaints will go through the same process. This will allow a doctor's fitness to practise to be considered from every aspect instead of having to be dealt with under separate health, performance or conduct procedures. With some minor exceptions, the same outcomes and sanctions will be available to apply in every case as appropriate.

All panellists will be appropriately assessed for suitability. No Council members will sit on the panels that decide the case against a doctor.

The new procedures will streamline the whole process and ensure that complaints are progressed as promptly as is consistent with achieving fairness.

New licence to practise and revalidation

The GMC's register of doctors has traditionally depended on a once-only check on a doctor's qualifications, training and experience undertaken at the point of first registration.

In the new system, to be introduced in 2005, every doctor who wants to practise medicine must not only be registered but also hold a licence to practise from the GMC. Licensed doctors will also have to be revalidated by the GMC every five years. Doctors will have to demonstrate that they have been practising medicine in accordance with the principles set out in the GMC's key guidance publication, *Good Medical Practice*.

The changes are intended to ensure that doctors are up to date and fit to practise medicine throughout their careers, not just when they first apply. They also aim to modernise regulation and increase public confidence in doctors.

The GMC has worked closely with the UK departments of health in setting up the new system.

Qualified to practise

Better assessment of the doctors the UK needs

The quality of the registration process is key to ensuring doctors have the medical knowledge and skills needed to practise in the United Kingdom.

The registration process

It drives everything the GMC does and delivers the increasing numbers of highly qualified doctors the country needs – the continuous, painstaking work of assessing the competence, skills and knowledge of doctors from the UK and all over the world. Every doctor who wants to practise medicine in this country must have a recognised medical qualification and hold registration with the GMC. Ensuring every aspect of registration is rigorous, efficient and fair is a top priority. The quality of the registration process is regarded as the key to ensuring doctors have the requisite medical knowledge and skills needed to practise in the United Kingdom.

In 2003, the GMC assessed record numbers of doctors – over 18,000 compared with around 11,000 in an average year. Three out of ten qualified at UK medical schools, around 15% from the rest of Europe and 55% from other parts of the world. It is a telling figure, and highlights why international medical graduates are so important to the future of healthcare in the UK. The GMC's policy is to ensure that all doctors are treated equally, no matter where in the world they qualified. The year was notable for the success of measures to speed up the registration process and deal promptly with the upsurge in applications.

Much activity focused on preparations to replace registration arrangements unchanged since the 1970s with a new system of registration and licensing. As part of a major review of registration, a wide-ranging consultation was carried out among health professionals in the UK and overseas, consumer bodies and patient organisations.



“The new single system of licensure is a great step forward in achieving fairer entry and diversity in the medical workforce in the UK.”

Christine Payne GMC staff



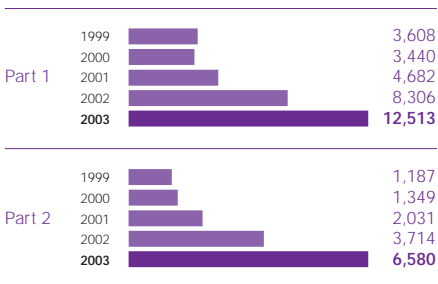
“I welcome the GMC’s announcement of the introduction of the new licence to practise and regular revalidation for doctors. In developing annual appraisal for NHS doctors we have worked very closely with the GMC throughout to ensure that our plans dovetail with their proposals for revalidation. The two processes together will help doctors to be safe, to keep up to date, and deliver high quality care to patients.” Liam Donaldson Chief Medical Officer for England

Developments will culminate in major reform of the entire registration process with the introduction of the new licence to practise and periodic revalidation (see page 9). It is planned to introduce the licence in early 2005 and to begin the first revalidations shortly afterward.

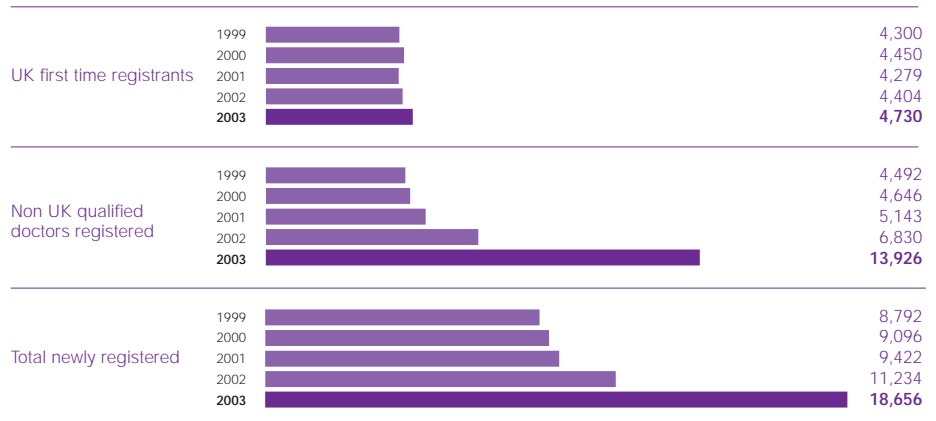
Equal treatment for international medical graduates

Ensuring that fair and consistent standards are applied to all doctors is more important than ever. By the end of 2003, new arrangements were in place to ensure equal treatment for all those who qualified outside the UK and the EEA. In the past, doctors from universities in Australia, Hong Kong, New Zealand, Singapore, South Africa or the West Indies (and the University of Malaya before 1990), were treated differently in accordance with Section 19 of the Medical Act. They were given direct access to full registration without first having to demonstrate their medical knowledge and skills. Following the GMC's successful lobbying to change the relevant legislation, it can now apply the same standards to everyone for the first time.

PLAB test places 1999 – 2003



Registration 1999 – 2003



The next step will be to abolish the concept of 'limited' registration for international medical graduates. At present, those who have qualified outside the UK or EEA can only apply for limited registration – a system that can appear unfair and is complex and expensive to maintain. New arrangements will apply the same licensing framework to every applicant, regardless of where in the world they qualified. When international medical graduates have demonstrated their medical knowledge and skills they will be able to apply for the same full licence as their UK counterparts. The forthcoming system of a licence to practise and periodic revalidation will apply to all doctors.

A wide-ranging consultation was carried out about the proposed changes to registration arrangements. It drew an overwhelmingly supportive response. Those invited to take part included consumer bodies and patient organisations, medical defence societies, NHS employers, overseas medical regulators and higher education institutions, private health insurers, private sector employers, professional bodies and associations, recruitment agencies, GPs, the Department of Health and other UK health regulators and higher education institutions.

The importance of English language testing was among the issues highlighted. The legal position prevents English language tests being applied to applicants from EEA countries. The GMC supports Department of Health advice to employers about the importance of assessing English language skills.

Safeguards for the public are being strengthened by introducing identity checks for all doctors when they register. A Certificate of Good Standing (CGS) will be required from other medical regulators around the world. An internal guide to those regulators from whom the GMC will accept a CGS has been prepared. All claims must be verified in order to ensure that any disciplinary proceedings are disclosed.

Opening of new Clinical Assessment Centre

The two-part PLAB test – set by the Professional and Linguistic Assessments Board – is a key component in assessing the ability of overseas doctors to work safely in UK hospitals. It combines practical testing with written tests that can either be taken in the UK or through the British Council in selected overseas countries. During 2003, important steps were taken to make the PLAB testing process more efficient and deal with the growing number of applicants. The GMC opened its first purpose-built testing centre for overseas doctors.

This new Clinical Assessment Centre will boost the number of places available for practical tests from around 7,000 in 2003 to 9,000 in 2004, while increasing quality control and consistency of testing for candidates. The centre simulates a practical environment much like an Accident and Emergency department, testing diagnostic, examination, communication and other key skills. Tests are highly realistic, using trained actors to play the role of patients and manikins to test clinical skills such as suturing, taking blood and catheterisation. By the end of the year, the Centre was already having a significant impact. More than 460 candidates took their exams during the last two months. There was no longer any need to hire accommodation from other organisations.

Greater use is being made of the internet to speed applications by international medical graduates. Candidates can now check their written test results and apply to take the practical tests online.

An increasing proportion of doctors passing the PLAB test are taking up employment in the UK. Historically, just over 85% did so. It is known that not everyone who takes the PLAB test intends to work here immediately. Even so, 90% of doctors who took the test in 2002 did get a job in the UK. As with any employment market, competition in some locations and specialties may make it difficult for doctors to secure a first post in their chosen field or location.

The GMC sets the standard for those wishing to work in the UK but manpower planning is not primarily our responsibility. There have been calls for the GMC to limit or ration the PLAB test, but it does not believe it would be right to do so. However the GMC recognises the difficulties that some doctors report in entering the UK job market and is keen to work with others who are better placed to ensure doctors coming to the UK from abroad have the relevant market and induction information they will need.

Supporting refugee doctors

Refugee doctors represent a very small proportion of doctors seeking registration but the GMC recognises the need to provide all the help it can. Since 2001 it has offered a discount on fees for the written part of the PLAB test. As PLAB tests are self funding, waiving the fee altogether would disadvantage other candidates. However it is planned to increase assistance by offering further concessions including a discount on the practical test and allowing payment by quarterly instalments, starting in February 2004.

2003 service standards in reception

Total visitors	22,390
No. seen in 10 minutes	20,805
% seen in 10 minutes	93%



“Continuing professional development is a key issue, and it will be a big challenge to ensure that it can be fitted within young doctors’ working hours.” David Davidson Scottish Conservative Party Health Spokesman



“Given that society’s needs will continue to evolve over the doctors’ working lifetime, more emphasis needs to be placed on equipping students to adapt and change to meet new demands.” Professor John Tooke
Dean, Peninsula Medical School

Putting education first

A professional approach to education and training

As part of its developing quality assurance system, the GMC aims to identify and spread good practice throughout medical education.

A professional approach to education and training

The GMC recognises the fundamental importance of education and training to doctors and patients and regards upholding quality and spreading best practice as part of its core role. It has a statutory responsibility to promote high standards and co-ordinate all stages of medical education. In doing so, it works in close partnership with all parts of the UK medical education sector, which has an international reputation for innovation.

In 2003 the GMC's reconstituted Education Committee, chaired by Professor Peter Rubin of Nottingham University, continued a major review of education activities. New procedures for quality assuring the UK medical schools were prepared for piloting at volunteer schools. *Tomorrow's Doctors*, dealing with undergraduate medical education, was reissued. *The New Doctor*, for graduates entering medical practice, was thoroughly revised prior to consultation. And consultation took place over the GMC's first guidance on continuous professional development (CPD), which was published in April 2004.

Publication of new guidance

A major informal consultation was held on Pre-Registration House Officers (PRHO) training, incorporating revision of *The New Doctor*. The idea has been to take a radical look at the current format of the year that provisionally registered doctors spend in training after graduation and see whether this could be made more appropriate to modern medical practice. Feedback has been sought from a wide range of stakeholders in the profession, consumer bodies and patient organisations.

The subsequent formal consultation taking place in 2004 has been welcomed by the chief medical officers for England, Scotland, Wales and Northern Ireland as a step towards plans for a new foundation programme spanning the first two years of a doctor's career (put forward in the Department of Health programme Modernising Medical Careers).

The new issue of *Tomorrow's Doctors* incorporates guidance on student health and conduct within the GMC's recommendations on undergraduate medical education. *Tomorrow's Doctors* sets the standards according to which the GMC quality assures UK medical schools.

Reflecting contemporary society

As part of its developing quality assurance system, the GMC aims to identify and spread good practice throughout medical education. Medical schools are being encouraged to consider potential future needs through the 'Reflecting Contemporary Society' programme launched in 2003. Key strands include taking a more 'patient-centred' approach, looking at how factors such as higher levels of education and an ageing population could affect relationships between doctors and patients. The speed with which medicine is changing will transform medical practice in the coming decades. Medical schools will therefore need to be more 'learner centred', leaving doctors with a commitment to, and competence for, life-long learning. Inter-professional learning is another key strand of the programme – ensuring that doctors understand the knowledge, skills and values of other professional groups such as nurses and physiotherapists. Education must take account of the heterogeneous nature of today's society by promoting equality and diversity.

Medical schools are also being encouraged to acknowledge the permanence of change and the impact this is likely to have on science, society and the structure of health services. The discussions with medical schools on these themes will be taken into account when *Tomorrow's Doctors* is next revised.

Professional standards and partnership

The drive for quality assurance and professionalism was extended with a new pilot scheme for medical schools and a new recruitment programme for the GMC's visitors to the schools. The Education Committee is continuing to require an update on any major changes to medical curricula on an annual basis, and schools will be visited at least twice every ten years. The new medical school visitors were recruited against competencies and will be subject to regular appraisal.

The GMC has extended its partnerships with a wide range of other organisations in the education sector. It is co-operating closely with the new Postgraduate Medical Education and Training Board (PMETB) and with those taking forward the agenda of 'Modernising Medical Careers' in relation to postgraduate training. The reconstituted Education Committee includes nominees from the Academy of Medical Royal Colleges (AMRC), the Council of Heads of Medical Schools (CHMS), the Conference of Postgraduate Medical Education Deans (CoPMED), the Joint Committee on Postgraduate Training for General Practice (JCPTGP), the Specialist Training Authority (STA) and PMETB. The Education Section and Committee maintain close contact with organisations representing educators, students and trainees.

Setting the standard

Guiding doctors and policy makers Giving guidance to doctors on standards of professional conduct and on medical ethics goes to the heart of what the GMC is all about.

All doctors must place their duty to the patient above everything else and the GMC's role is to provide all the information and advice they need. Giving guidance to doctors on standards of professional conduct and on medical ethics goes to the heart of what the GMC is all about, and this focus is reinforced by the reform programme now underway.

The publication *Good Medical Practice* sets the agenda for this vital aspect of the GMC's work, putting into plain, concise English the principles of good medical practice and standards of competence, care and conduct that are expected of every doctor. It has been widely adopted around the world and translated into languages as diverse as Estonian, Japanese and Portuguese.

Guidance must be constantly updated where necessary to reflect changes in the medical profession and society. In 2003, new advice was published about treating patients with gunshot wounds. Updated guidance on prescribing was prepared for publication in 2004, reflecting concerns over slimming clinics and growing use of the internet and telephone. Revised guidance on confidentiality was also prepared.

Working proactively in partnership with other organisations and the public, and with stakeholders in Westminster and the devolved parliaments, the GMC tackles concerns about aspects of forthcoming legislation. During the year work was progressed on drawing up a code of practice to protect patients' rights to confidentiality affected by the Health and Social Care Bill.

New and updated guidance

The new guidance on gunshot wounds reflects growing concern about the impact of gun crimes on communities and the need to ensure that potential evidence is not destroyed. The GMC worked closely with the Association of Chief Police Officers (ACPO) in England and the British Association for Accident and Emergency Medicine, and took into account views of patients and the profession. The outcome balances the public interest with the wishes of patients. Advice makes it clear that doctors must inform the police when a patient seeks treatment for a gunshot wound. It clarifies the position on disclosing identity and other information when this could prevent others suffering harm or help tackle a serious crime.

The GMC is working proactively in partnership with other organisations and the public, and with stakeholders in Westminster and the devolved legislatures.

The new guidance was welcomed by the police, who expect it to assist in the detection of offences. It balances this need with the importance of ensuring that patients presenting to emergency departments with gunshot wounds receive the highest standards of clinical care.

The GMC's revised guidance on confidentiality deals with concerns expressed – particularly by the research community – over the need to obtain patients' consent before data is used for anything other than care. Publication took longer than expected because of the need to consult and resolve views of conflicting interest groups and was delayed from 2003 to 2004.

Speeding up the consultation process is an objective for the coming year. One aim is to change and update information more swiftly by making greater use of the internet and *GMC News* to respond to frequently-asked questions. With the death of Victoria Climbié and other cases of child abuse in the news, further questions are anticipated about disclosure of information and the need to protect children. It will be important to respond swiftly to these questions.



“I recognise the unique contribution of the General Medical Council in assuring the quality of health care and its innovative work in introducing revalidation for all medical practitioners. I am therefore particularly pleased to welcome the establishment of a new GMC Scottish office to help ensure progress with this important programme.” Malcolm Chisholm Scottish Minister for Health and Community Services



“Lay participation in the health service is no longer seen as desirable but expected as a professional way of working. Speaking as a member of the GMC’s Patient Reference Group, I am most impressed with how the views of the group have been reflected and, moreover, actively sought in the development of key policy documents and strategies. The GMC should be proud of this approach which is being replicated by other regulatory bodies.”
Christine Johnstone Chief Officer, Fife Health Council

Advising on legislation

Serious concerns over patient confidentiality were aroused by the Health and Social Care Bill. Clause 66 of the Bill would have given the new Healthcare Commission wide powers in England and Wales to access records including those of individual patients. The GMC and partner organisations carried out a successful lobbying campaign to amend the legislation. Together with the Nursing and Midwifery Council and the Consumers’ Association, it argued that patient confidentiality should be given greater weight.

Following a debate in the House of Lords, it was agreed that the GMC and the Healthcare Commission would develop a robust code of practice for consideration. The GMC welcomed the opportunity to work together and ensure that the Healthcare Commission would have access to the information it needs to monitor and improve standards of care while protecting patients’ rights.

The GMC raised its profile at party conference activities during the year. Speaking at a fringe meeting organised by the Institute of Public Policy Research, the President gave information about the confidentiality issue and also explained the GMC’s proposal for a unified gateway for patients’ complaints.

Scotland, Wales and Northern Ireland

In Wales, Scotland and Northern Ireland, the GMC has been increasing its engagement with parliament and assembly members, policymakers and patient organisations.

The GMC now has permanent representation in Scotland. The new Scottish office was established in 2003 and moved into central Edinburgh premises in March 2004. The three-strong team is responsible for engaging with the Scottish Executive and other stakeholders, patients and professional groups. Significant progress has been made in ensuring that Scottish structures for clinical governance and appraisal fit with the requirements of GMC revalidation. Memoranda of Understanding are in hand with a variety of Scottish bodies.

Scottish health policy and the administration of the NHS in Scotland is devolved to Holyrood, which leads to clear differentiation in areas such as the implementation of the 2003 Mental Health Act (Care and Treatment) and the fundamental structural changes that will be brought about by the NHS (Scotland) Reform Bill. The twin track approach to controversial issues such as organ retention underlines the importance of a GMC Scottish office.

A higher international profile

Campaigning for higher standards around the world

The GMC aims to be much more proactive in Europe, working with other regulatory bodies to raise issues of concern and safeguard patients.

International public affairs activity in 2003 focused on Europe, where the GMC and other regulators drew attention to fears that a proposed directive on free movement of professionals could jeopardise patient safety.

Under the proposed draft Directive on the Mutual Recognition of Professional Qualifications, healthcare professionals from any EU country would have been allowed to work in the UK for up to four months a year without having to register here. In the event of problems with patient care, health regulators would have been powerless to take action and unable to stop the same thing happening again.

A highly successful campaign highlighting these concerns was led by the Alliance of UK Health Regulators on Europe. AURE was set up to campaign for better standards across the European Community in partnership with the GMC and nine other UK regulatory bodies – the General Dental Council, General Optical Council, General Osteopathic Council, General Chiropractic Council, Health Professions Council, Nursing and Midwifery Council, Royal Pharmaceutical Society of Great Britain, General Social Care Council and the Pharmaceutical Society of Northern Ireland.

In November, following an intensive lobbying campaign, the Legal Affairs Committee of the European Parliament agreed to put forward amendments to safeguard patients. MEPs subsequently voted (in February 2004) to support the call for health and social care professionals to be registered with the relevant authorities in order to practise.

The impact that AURE has achieved demonstrates how the GMC and its partners can successfully tackle key issues on the European stage. The 2003 campaign was necessarily reactive and defensive but now the GMC aims to be much more proactive in Europe, working with other regulatory bodies to raise issues of concern and safeguard patients. The Department of Health has asked AURE to participate in planning for the UK Presidency of the EU in 2005.

International links

The GMC has a high reputation around the world, particularly in relation to its standards policy guidance and initiatives on education. International delegations from countries including Colombia, China, Japan, Korea and Panama were welcomed in 2003. In Albania, with funding from the Department for International Development, GMC advisers have been helping to set up an effective regulatory system.

Preparations began for the forthcoming conference of the International Association of Medical Regulatory Authorities (IAMRA), which meets in Dublin in 2004.

“The importance of professionally-led regulation cannot be overstated. It is becoming increasingly important that efficient registration mechanisms are in place given Britain’s increased reliance on health professionals trained overseas, and in light of the forthcoming expansion of the European Union. It is also extremely important for health professions to have effective governing bodies which can ensure that the interests of patients are put before all other CONCERNS.” John Baron MP, Conservative Health Spokesman

Dealing with complaints about doctors

Putting decision making on a more professional footing

The GMC must treat doctors with complete fairness but always place public protection first.

The GMC responds to complaints about doctors through its fitness to practise procedures and has legal power to act where complaints are upheld. It must treat doctors with complete fairness but always place public protection first.

As part of the GMC's reform programme (see page 9), a fitness to practise review was carried out and a new, unified complaints process is being introduced. Much of the preparatory work had been completed by the end of 2003, including recruitment of the first case examiners. Putting the conclusions of the fitness to practise review into practice has taken longer than expected and will now be implemented in the second half of 2004. The delay has afforded more time to agree new rules and offers scope to reflect on the conclusions of the Shipman Inquiry.

Significant improvements in service standards were achieved in a year when the GMC set up its own in-house legal team for the first time.

Enquiries and complaints about doctors received 2001 – 2003

2001	4,504
2002	3,937
2003	3,962

Separating investigation from adjudication

The key element of the reforms of the complaints about doctors process is the separation of investigation from adjudication. Until 2003, complaints about doctors could be both screened, investigated and heard by Council members. Under the new system, Council members will no longer be eligible to sit and hear cases at adjudication.

A new Investigation Committee will largely delegate cases to case examiners who will be appropriately qualified GMC employees with a range of backgrounds, including both medically qualified and lay people.

Enquiries and complaints about doctors concluded 2001 – 2003

2001	5,348
2002	5,539
2003	4,468

In future, case examiners will be the key decision makers, responsible for ensuring that all complaints about doctors are handled efficiently, effectively and objectively. They will decide whether complaints about doctors should be referred for consideration by a fitness to practise panel.

The change is seen as a highly significant step in putting decision making on a more professional footing. The entire process will be less complicated as issues will no longer have to be categorised under separate headings for health, performance or conduct. Instead all complaints about doctors will be dealt with in a similar way.

The key element of the reforms of the complaints process is the separation of investigation from adjudication.

The first five case examiners were recruited in 2003. They were appointed in open competition through an objective recruitment and assessment process involving the Office of the Commissioner for Public Appointments (OCPA) and an external recruitment agency. The rigorous process is designed to ensure that candidates have all the required skills and competencies they need. In addition, these appointments aim to reflect the diversity of both doctors on the register and public and patients at large across the UK.

“At the heart of professional practice in medicine is the need to ensure that patients can trust doctors with their lives and well-being. The medical profession has warmly embraced this benchmark as one against which they should be judged. If we are earnest and committed to the revalidation process within a framework or environment of clinical governance we can be confident of maintaining the undoubted trust in which doctors are held by the public.” **Dr Henrietta Campbell** Chief Medical Officer for Northern Ireland

“The public will never be convinced that the GMC is not an organisation of doctors looking after doctors unless we have effective lay participation throughout all aspects of the GMC’s work. The process of satisfying public expectations is about open dialogue and a commitment to deliver realisable benefits for patients. The profession must continue to be serious about their part in this process and willing to make the changes that flow from it.”

Claire Brown GMC staff



“Like all health care regulators the GMC must work ceaselessly to earn the respect of both its registrants and the public. Success on both counts will benefit both the medical profession and the patients it serves.”

Hew Mathewson President, General Dental Council

The same emphasis is being placed on professionalism of training programmes for legal assessors, case examiners and all those who are responsible for decision making. During the year, everyone who chairs or sits on fitness to practise panels underwent professional assessment. Once again, the aim is to ensure that they possess the skills and competencies required to exercise good judgement and make appropriate decisions.

The reform package will make decision making more transparent, clarify appropriateness and resolve cases more speedily.

2003 sanctions against doctors

Erasures

At PCC	47
Voluntary	85
Under section 30(5)	5
Under fees regulations	5
Total erasures	142

Suspensions

Conduct/conviction	20
Health	53
Performance	10
Total suspensions	83

Conditions

Conduct/conviction	31
Health	70
Performance	29
Total conditions	130

The reform package will make decision making more transparent, clarify appropriateness and resolve cases more speedily. Throughout its fitness to practise work the GMC aims to be more transparent at every stage and more open in all dealings with doctors. Continued development of audit procedures is taking place. Outcomes of cases must be appropriate, ensuring that both parties have been fairly treated while placing public protection first.

New policy on disclosure of fitness to practice information to employers was agreed by Council in 2003. Information can now be released when case examiners or the registrar have decided that an investigation is justified. A widespread consultation process on other disclosure issues started in early 2004. Data protection legislation, the European Convention on Human Rights and Common Law have all complicated the position on when to reveal to an employer a doctor's fitness to practise history. Decisions are particularly difficult when cases have been concluded and there are no current sanctions. This issue reflects the GMC's role in a broader regulatory environment, working in partnership with other organisations, patients and the public.

Setting up an in-house legal team

Setting up an in-house legal team at the GMC for the first time was one of the year's most significant developments. By the end of the year, 12 lawyers had been recruited and started taking on a growing proportion of presentational and investigative work, most appeals and all judicial reviews. The full team will comprise more than 20 staff, of whom up to 15 will be lawyers.

As well as keeping legal costs down, the team will be able to provide legal advice to decision makers at every stage of a case. More active investigation is planned and information will be shared with other organisations that have clinical governance responsibilities. The GMC's objective is to ensure a free flow of information among professional bodies that employ doctors.

“Something as minor as not following up a phone call, or having faulty or outdated equipment, can lead to serious consequences for patients if left unmonitored. Formal quality checks minimise risk to all aspects of patient care.”

Cara Talbot GMC staff



Members of the General Medical Council from 1 July 2003

Lay members

Rt Hon Kevin Barron MP
Mr David Bean QC
Sir Michael Buckley
Mrs Gillian Camm
Ms Ruth Evans
The Very Reverend Graham Forbes
Mr Stuart Heatherington
Mr Robin MacLeod
Dr Joan Martin
Dr Arun Midha
Mrs Patricia Moberly
Mr Robert Nicholls
Mrs Fiona Peel
Mrs Ann Robinson

Medical members

Dr Rachel Angus
Dr Sathiyakeerthy Ariyanayagam
Dr Edwin Miles Borman
Mr Stephen Brearley
Professor Christopher Bulstrode
Professor Sir Graeme Catto *President*
Professor James Drife
Dr Alexandra Freeman
Professor Peter Hutton
Dr John Jenkins
Dr Brian Keighley
Dr Krishna Korlipara
Dr Malcolm Lewis
Professor Mike Pringle
Dr Rosalind Ranson
Professor Wendy Savage
Professor Robert Shaw
Mr Robert Slack
Dr Peter Terry
Dr Nicola Toynton
Dr Joan Trowell



Committee Chairmen

Education Committee

Professor Peter Rubin

Standards Committee

Ms Ruth Evans

Fitness to Practise Committee

Dr Joan Trowell

Preliminary Proceedings Committee

Professor Sir Roddy MacSween

Registration Committee

Mr Stephen Brearley

Review Board

Dr John Biggs

Resources Committee

Dr Arun Midha

Audit Committee

Dr Nicola Toynton

Remuneration Committee

The Very Reverend Graham Forbes

Race Equality and Diversity Committee

Dr Edwin Borman

Interim Orders Committee

Professor Norman MacKay

Committee on Professional Performance

Professor David Hatch

Health Committee

Dr Jane Wood

Professional Conduct Committee

Professor Robert Dickson

Assessment Referral Committee

Miss Caroline Doig

Patient Reference Group

Rt Hon Kevin Barron MP

Summary financial information

Balance sheet (£000s)	2002	Draft accounts 2003
	Tangible fixed assets	1,955
Investments	18,952	23,313
Net current assets	13,438	22,944
Net funds	34,345	50,077

Income and expenditure (£000s)	2002	Draft accounts 2003
	Income	55,675
Expenditure	44,710	47,665
Net (outgoing)/incoming resources	10,965	12,653
Net (losses)/gains on investments	(4,078)	3,079
(Deficit)/surplus before exceptional items	6,887	15,732

Income (£000s)	2002	Draft accounts 2003
	Annual retention fee	44,214
Registration fees	2,942	3,427
Provisional + Limited registrations	3,111	3,272
PLAB test	2,863	4,705
Miscellaneous fees	1,436	2,012
Publications and other income	181	143
Net investment income	929	1,496
Total income	55,675	60,318

2003 Expenditure

Fitness to practise	57.2%
Registration	15.3%
PLAB test	7.9%
Revalidation	1.8%
Education	1.7%
Standards	1.5%
Legislation & Policy	4.1%
Support & Accommodation (Resources)	0.0%
Management & Administration	10.5%



The statement of income and expenditure shown above is an extract from the GMC's unaudited accounts. The audited accounts will be published later in the year.

“Today patients take on trust far less from clinical professionals than before. They expect good communication and information from their doctors. Regulators such as the GMC have to be rigorous in their approach across a broad range of competencies. There is currently a great danger that a proliferation of regulators will overwhelm a medical profession already finding it difficult to adjust to a new patient culture.” **Lord Clement-Jones** Liberal Democrat Health Spokesman

Democrat Health Spokesman

“The main issue for medical regulation is to make revalidation a reality – to convince the profession and the public that it is an improved way of ensuring public safety but also to be clear on its limitations, so as not to raise excessive expectations.” **Jane Ashwell** Health Professional Group, Welsh Assembly Government

Group, Welsh Assembly Government



“As a Commissioner on the Commission for Patient & Public Involvement in Health I greatly welcome the development of revalidation. However, I do believe that lay people will have to have more input into that process.”

Arnold Simanowitz Commissioner, Commission for Patient & Public Involvement in Health

“Actions speak louder than words – all health regulators must continue to be open, responsive, consistent and publicly accountable. In doing this, we must recognise high public expectations and manage frequent misconceptions about the UK’s regulatory frameworks.” **Margaret Coats** Chief Executive, General Chiropractic Council

Useful GMC contacts

Checking a doctor's registration

Telephone 020 7915 3630
Fax 020 7915 3558
Email registrationhelp@gmc-uk.org

GMC publications

Telephone 020 7915 3507
Fax 020 7915 3685
Email publications@gmc-uk.org

The GMC and medical education

Telephone 020 7915 3506
Fax 020 7915 3599
Email education@gmc-uk.org

Fitness to practise enquiries

Telephone 020 7915 3603
Fax 020 7915 3642
Email practise@gmc-uk.org

Health procedures

Telephone 020 7915 3580
Fax 020 7915 3634
Email health@gmc-uk.org

Performance procedures

Telephone 020 7915 3603
Fax 020 7915 3680
Email performance@gmc-uk.org

Inquiries about standards and ethics

Telephone 020 7915 3568
Fax 020 7915 3599
Email standards@gmc-uk.org

Licences to practise and revalidation

Telephone 020 7915 3630
Fax 020 7915 3532
Email registrationhelp@gmc-uk.org

Main switchboard and fax *London*

Telephone 020 7580 7642
Fax 020 7915 3641
Email gmc@gmc-uk.org

Manchester

Telephone 0161 923 6200
Fax 0161 923 6201
Email gmc@gmc-uk.org

Edinburgh

Telephone 0131 240 6410
Fax 0131 220 0120
Email gmcscotland@gmc-uk.org

Media relations

Telephone 020 7915 3720
Fax 020 7915 3685
Email pressoffice@gmc-uk.org
www.gmc-uk.org/pressoffice

GMC web site www.gmc-uk.org

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- be honest and trustworthy;
- respect and protect confidential information;
- make sure that your personal beliefs do not prejudice your patients' care;
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor; and
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

