

Safe hands

Positive prognosis

Shaping the future of medical regulation
A review of the work of the GMC in 2000



Looking forward



President's foreword

- Good medical practice

Review of the year

- Delivering change

The challenge

- Building a more responsive organisation

Complaints

- Acting when things go wrong

Your decision

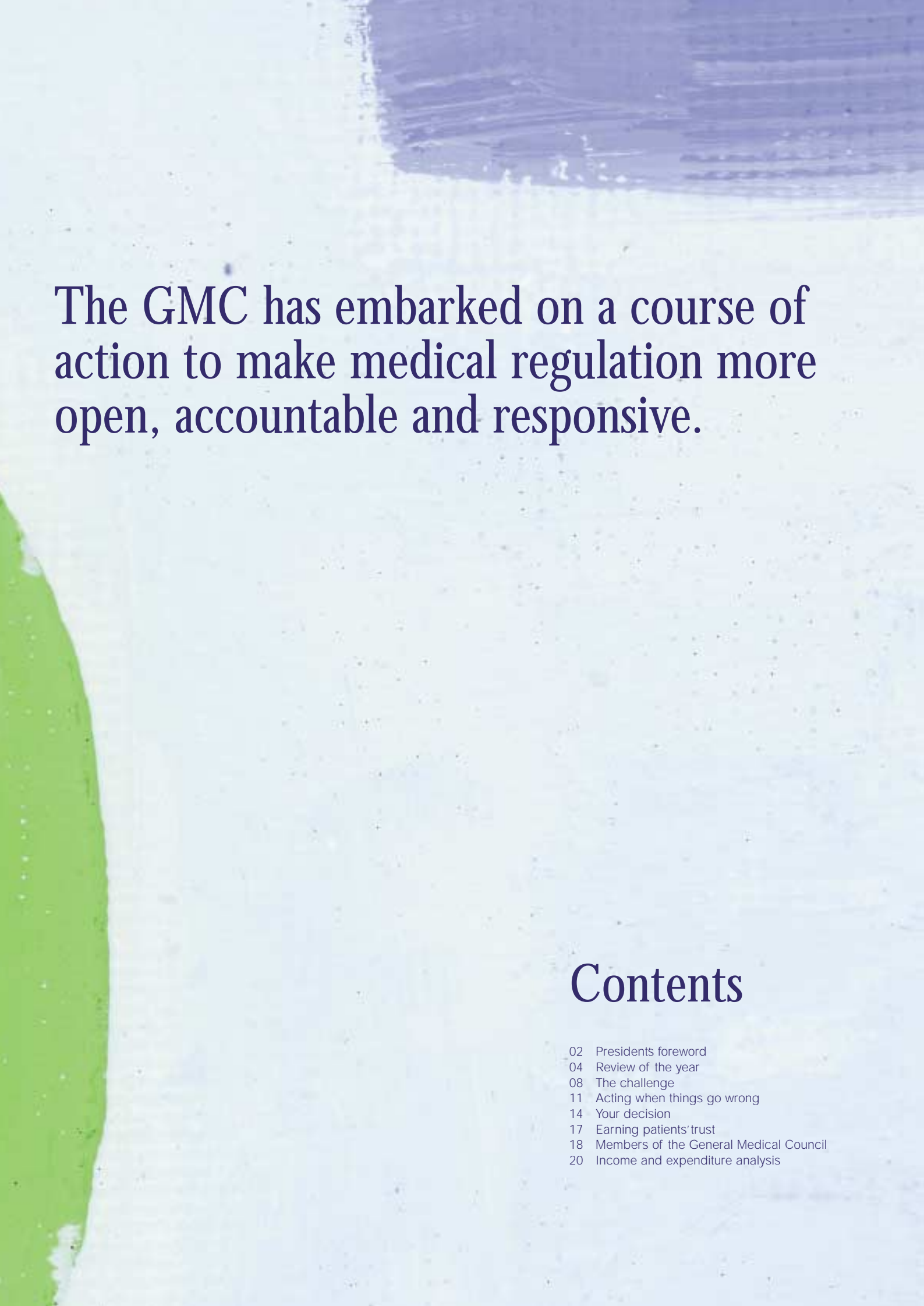
- The ethics of consent

Earning patients' trust

- The development of revalidation

**GENERAL
MEDICAL
COUNCIL**

*Protecting patients,
guiding doctors*



The GMC has embarked on a course of action to make medical regulation more open, accountable and responsive.

Contents

- 02 Presidents foreword
- 04 Review of the year
- 08 The challenge
- 11 Acting when things go wrong
- 14 Your decision
- 17 Earning patients' trust
- 18 Members of the General Medical Council
- 20 Income and expenditure analysis

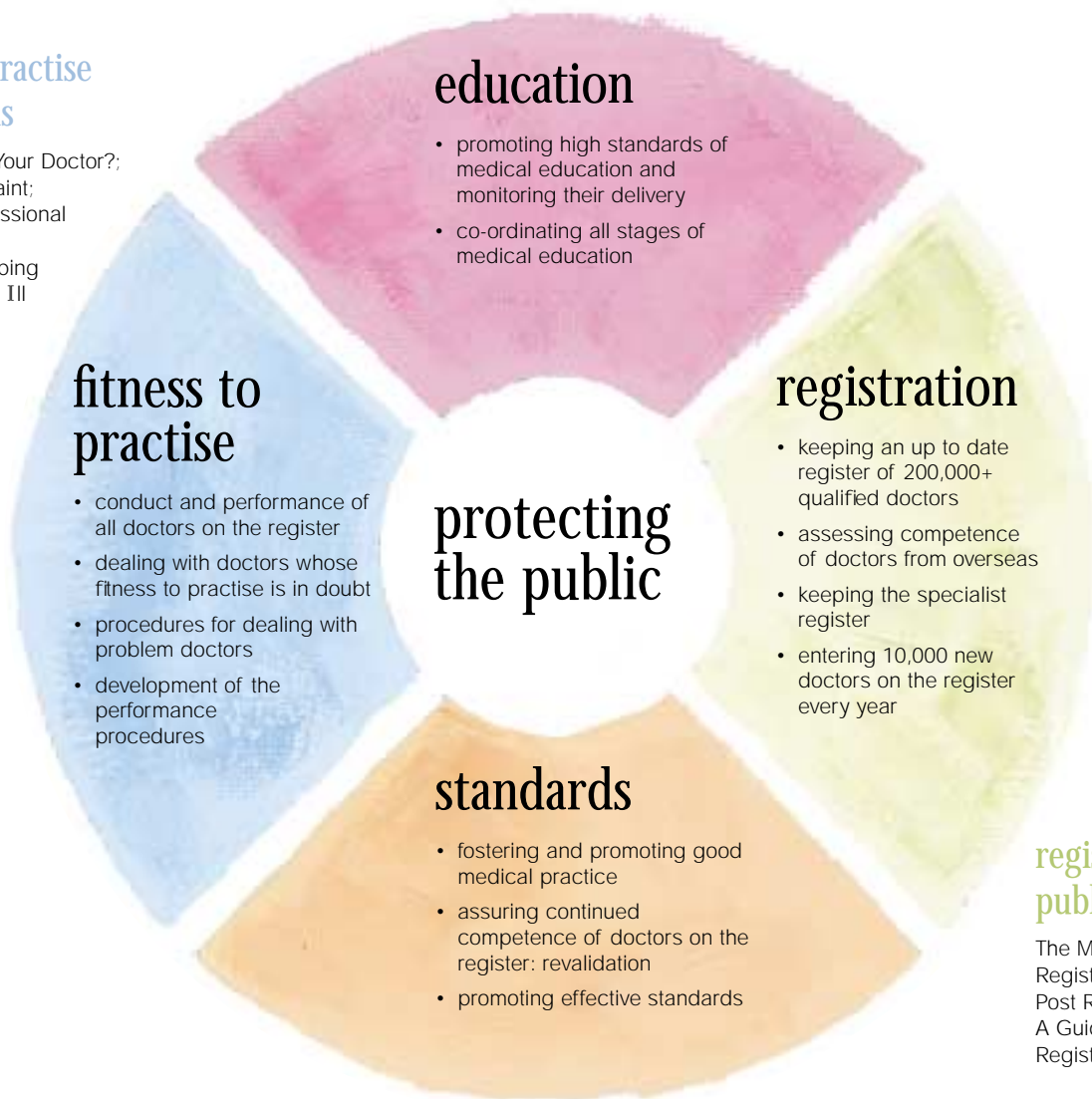
The role of the GMC

education publications

Tomorrow's Doctors; The New Doctor; Early Years; The Doctor as Teacher; Student Health and Conduct

fitness to practise publications

A Problem with Your Doctor?; Facing a Complaint; When Your Professional Performance is Questioned; Helping Doctors who are Ill

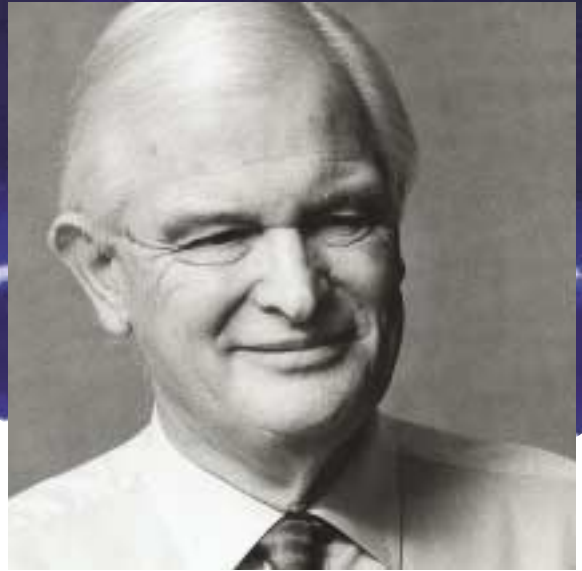


registration publications

The Medical Register; Registration; Post Registration; A Guide to the Registers 2001

standards publications

Good Medical Practice; Seeking Patient's Consent; Confidentiality; Management in Healthcare; Maintaining Good Medical Practice; Serious Communicable Diseases; The Local Medical Regulation Handbook



Sir Donald Irvine
President

President's foreword

Medical regulation is professionally-led and in partnership with the public.

GMC registration should be synonymous with good medical practice.

The year 2000 has been a watershed in the life of the GMC. Despite being a difficult year, the GMC is now well down the road to becoming a very different body. The safe care of patients by doctors is at the heart of everything we do. Medical regulation is professionally-led and in partnership with the public.

In our five-year review, published this time last year, I wrote about the new relationship developing between the medical profession and the public. There is now widespread acceptance amongst doctors that the profession needs to be more open, transparent, responsive to patients and the public, and properly accountable. These changes in medical culture, reflected in medical practice and in the operation of the regulatory system, should go a long way in sustaining public trust in the profession and the profession's sense of confidence in itself.

Maintaining good medical practice, through quality assurance in clinical teams and early local action when problems arise, must be the right way forward.

The GMC's plans for strengthening professionalism in medicine and professionally-led regulation proceed apace. We are sure of both the extent and the limits of our responsibilities. Essentially, the public expects the GMC to keep a register of doctors who are up-to-date and fully competent to practise in their chosen field. GMC registration should be synonymous with good medical practice.

The steps needed to give our purpose practical effect are embodied in our main functions. In terms of professional standards we are about to publish the third edition of *Good Medical Practice*. This sets out the duties and responsibilities of doctors and so codifies what the public and the medical profession agree is expected of each doctor. We are linking these professional standards explicitly to registration through revalidation, so that the public will know that each doctor's practice has been regularly checked. We are strengthening our role in medical education to make sure that the system of medical education produces doctors who meet the GMC's professional standards. And a huge effort is going into fashioning a fresh approach to our fitness to practise procedures for handling doctors whose conduct, performance or health raises questions about their registration.

All these changes must be seen against the background of yet more deeply distressing cases involving the clinical performance and conduct of some doctors. Such cases distract from the efforts of the vast majority of good doctors, who feel let down by the poorly performing minority. But they do reinforce the need for the GMC, the NHS and the private sector to work together so that good practice can be properly supported and problem cases can be brought to light and acted upon much earlier. Maintaining good medical practice, through quality assurance in clinical teams and early local action when problems arise, must be the right way forward.

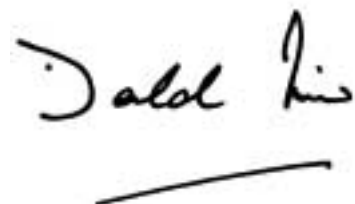
Prevention is better than cure. Clinical quality assurance is at the heart of clinical governance. It must be rigorous and systematic if it is to yield the results both the public and the profession are entitled to expect. This means a serious commitment by the NHS and other employers to make the investment in the people, data, skills, systems and time needed to achieve good results without overburdening clinicians or distracting them unnecessarily from patient care. Other service industries manage this. The health services should be no exception. And, of course, the better clinical governance and quality assurance are, the lighter can be the GMC's touch on revalidation.

Fitness to practise has been our greatest challenge. The huge rise in the number of complaints against doctors referred to the GMC over the past few years has caused unacceptable delays in bringing cases forward for hearing. In 2000 the number of complaints received increased by more than 40% compared with 1999. In part this rise is because of increased public and professional awareness. I am sorry about the delays. Fortunately with much effort and a big increase in staff numbers we are now much

more on top of case preparation. The delays have been most serious in getting cases already investigated actually heard before the Professional Conduct Committee. Following a change in the law last summer enabling us to recruit more panel members we are now acquiring the capacity needed to do the job. But gearing up takes time – so we would ask for forbearance.

As we go to press we are carrying out our final consultation on our proposals for revising the structure, constitution and governance of the GMC. And there is an important consultation paper setting out substantial changes to our fitness to practise procedures. It is very important that we hear what all our stakeholders have to say for we want to achieve a result which will be efficient and effective, and meet the expectations of as many people as possible.

This has been a testing year for all. I want to thank members of Council for their support and for the enormous amount of work all have undertaken, especially in fitness to practise. My thanks go equally to our staff for their tremendous efforts to meet difficult targets and ensure that the needs of the Council and, therefore, of the public, are met.



Sir Donald Irvine
President

Review of the year

Delivering change

The past year has seen significant progress in the GMC's programme of reform. Despite some testing challenges for the organisation, we now have detailed proposals to update our structure, constitution and governance and radical plans to overhaul the way we handle serious concerns about doctors.

High profile cases generated criticism of professionally-led regulation, the profession and the role of NHS management. In June, the BMA delivered a vote of no confidence in the GMC as it was currently constituted and functioning. So it is, perhaps, surprising that so difficult a year can be viewed as one of positive developments.

This has been achieved by keeping focused on our goals.

We have also gained support for the reforms achieved so far. The Government has reaffirmed its support for professionally-led regulation. Our determination and stamina have ensured that we have not been blown off course from delivering our reforms.

Delivering reform

The introduction of order making powers in the Health Act 1999 enabled some of the most important developments of 2000.

These powers enable the Government to more easily find Parliamentary time to change our legal framework. The Secretary of State for Health invited Parliament to use the procedure for the first time in July 2000 at our request, to give us tougher powers on restoration to the register, stronger powers of interim suspension, pending further investigation of a doctor, and the ability to recruit non-GMC members to our Professional Conduct Committee panels so that we could hear more cases much more quickly.

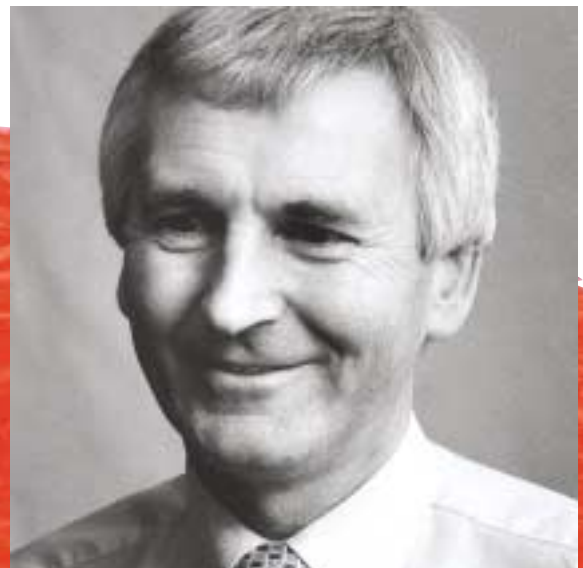
Our planned reforms include designing a new structure and constitution to give us the capacity for rapid decision making in changing circumstances. We are working towards a smaller body, meeting more frequently and with greater lay involvement.

We believe we are on the right track but we are not complacent. Much remains to be done and the launch of a consultation period, in Spring 2001, marks the final phase before definitive proposals are made to Government for a new look GMC.

Producing a high standard of service

One challenge we still face is delivering a consistent level of service of which we can be justly proud. In the past we know that we have fallen short of that goal.

We have introduced service standards in both registration and fitness to practise – where our workload has increased dramatically. Complainants now know how long consideration of their case should take.



Finlay Scott
Chief Executive

Revalidation will positively demonstrate that doctors remain up-to-date and fit to practise in their chosen field.

Since July of last year we have aimed to decide in 80% of new conduct cases, whether they should progress to the Preliminary Proceedings Committee within six months. We are now meeting that target for 81% of complaints. The challenge is to produce comparable standards for the performance procedures.

Last year we received 4,470 complaints, an increase of 40% on 1999. This has placed enormous pressure on staff and members.

Many complaints are properly redirected to other bodies and do not result in action by the GMC. Each however, is considered carefully by the GMC before being referred onwards.

We are determined to address the backlog which had developed and have already made progress. The 73 non-GMC members recruited (47 lay people and 26 doctors) have enabled three Professional Conduct Committee panels to sit in parallel. They received training and began to hear cases in November. Our fitness to practise directorate has grown from 64 to 90 out of a total staff of 241. We plan to recruit more non-GMC members for other fitness to practise work next year.

Year	Number of sitting days		
	PPC	PCC	IOC
1995	7	83	-
1996	5	77	-
1997	9	88	-
1998	7	91	-
1999	15	129	-
2000	30.5	242	16

Year	Total complaints received
1995	1,503
1997	2,687
2000	4,470

The patient is at the heart of everything we do

Demand for information about doctors on the register has increased dramatically. This reflects an increased realisation by employers of the importance of knowing their doctors have effective registration for the work they are doing. To improve our service to both doctors seeking registration and employers we took important steps towards introducing a new integrated registration computer system. The new system will be up and running during 2001.

We have continued to reinforce the message that the patient is at the heart of everything we do and are delivering tangible illustrations of this. The use of our new powers of interim suspension in August demonstrated our commitment to protecting patients.

Guiding doctors

In the guidance we issue to the profession we are becoming more patient focused. It is written from the perspective of what a good doctor would expect to do and also what a reasonable patient would want and we are involving patient groups far more in the development of that guidance. This approach will be reflected in the new edition of *Good Medical Practice* (our guidance to the profession) on which consultation began in December 2000.

We are also planning guidance for good practice in medical research and on withdrawing and withholding life-prolonging treatment from patients.

Giving meaning to the register

Registration used to be a historic record of a doctor's qualifications. The GMC decided this was no longer good enough and agreed to develop a system of revalidation - which would positively demonstrate that doctors remained up to date and fit to practise in their chosen field.

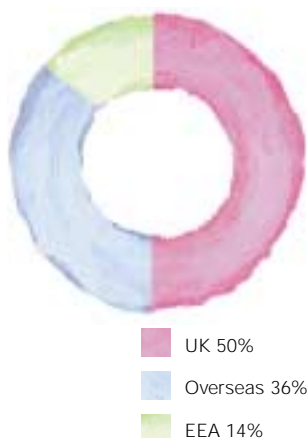
We have already started to pilot proposed models and are currently conducting an economic evaluation.

In May 2001 we aim to agree the model for revalidation. The challenge will be to implement this as economically and cost-effectively as possible. We must ensure that we respond to doctors' fears about how they will meet the requirements of revalidation.

Towards greater transparency

The level of scrutiny faced in 2000 reinforced our commitment to become a more open organisation.

Place of qualification for full new registrants 2000





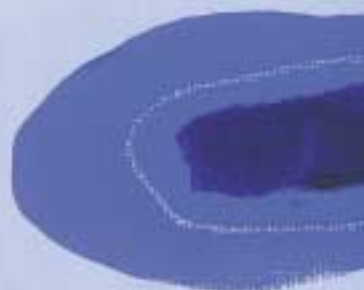
Staying On Course

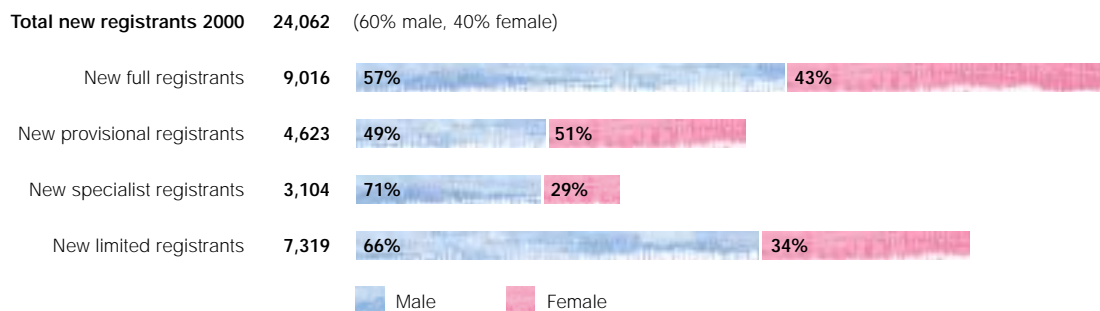


Getting fitter
Getting fitter
Getting fitter



On Course





The environment of change and uncertainty currently facing the profession has undoubtedly had a real effect on morale and we are not blind to that.

Review of the year (continued)

In developing revalidation proposals we have adopted an open, inclusive process. We have shared our proposals with consultative groups representing patients, doctors and managers at every stage.

The consultation process, launched in June, generated 1,047 replies and provided essential feedback to inform the pilot sessions which began in February 2001.

We are also trying to be more open about how we deal with complaints against doctors. Inevitably, because of the nature of our work some parts of our procedures will always be in private.

The Council is committed to increased openness and members agreed to provide details for a register of interests requiring them to declare a wide range of medical and non-medical interests. This register will be published in Spring 2001.

The wider picture

Our work in fitness to practise although the most reported area of our work must be seen in the context of the other important jobs we do.

In 1858 the GMC was established to identify qualified doctors. It was about controlling access to the register through education and this is still a fundamental part of what we do.

Every year we ensure that the doctors we put onto the register are well qualified with the appropriate knowledge and skills. Last year we registered 9,016 new doctors. 1,452 of these doctors came from other countries in the European Economic Area, 3,084 from outside Europe and 4,450 were UK graduates or UK trained.

In September we hosted an international conference on medical regulation. The conference established an International Association of Medical Licensing Authorities which will provide a network for regular exchange of medical licensing and disciplinary data about doctors.

Our role in medical education is expanding. Previously we concentrated effort on ensuring that medical schools' undergraduate curricula met our guidelines. This work will continue, in 2001, when we produce a new version of *Tomorrow's Doctors*, which will update our guidance to medical schools.

Our Education Committee has continued to visit medical schools to ensure that the implementation of *Tomorrow's Doctors* is on track. We will also start to work with the new medical schools announced last year by the Government to ensure that their curricula meet our standards.

In relation to the later stages of medical education, we have proposed establishing a series of advisory boards, under the Education Committee. These will look at particular phases of medical education and enable the committee to exercise its co-ordination function in the most effective way.

Overcoming obstacles to progress

The progress we have made so far has not been easy and there are hurdles still to come.

Our structures, constitution and governance have made it difficult to respond to a changing and challenging environment. Our plans for governance reform will help us to become fit for purpose.

We have suffered from processes, procedures and legislation which are arcane and out of date. The ongoing major review of our fitness to practise procedures along with the ability we now have to seek legislative change more easily will help us to attain our goal of becoming a model of professional regulation.

The environment of change and uncertainty currently facing the profession has undoubtedly had a real effect on morale and we are not blind to that.

We aim to win the argument that professionally-led regulation will deliver for patients. We need to provide an effective model of regulation and explain how we are doing it. We look forward to the benefits our reforms will deliver.

The challenge

Building a more responsive organisation

The GMC has initiated many changes in medical regulation in recent years. Introducing more lay members; working closely with medical schools to overhaul the way in which new doctors are educated; and the introduction of the performance procedures in 1997 are all examples. The GMC is committed to continuing its vigorous programme of reform.

What people want from their doctor has changed radically, as have their perceptions and expectations of the role of professional regulator. An organisation which is slow to act and slow to change are criticisms which have been made not just by the outside world but by GMC Council members too.

Procedures that were fit for purpose in the past have become outmoded and have highlighted the need for urgent, demonstrable change.

Addressing concerns and altering procedure has traditionally been a real challenge. Often the need for new policies or legislation has been identified by the GMC quickly but its cumbersome framework, coupled with the difficulty of gaining Parliamentary time has seriously hampered the process. The GMC first asked Government for legislation for a single form of registration for all doctors 12 years ago. But we continue to wait for the ability to make that change.

The aim was to build an organisation that can operate effectively and speedily, with input from all key stakeholders and much clearer lines of accountability.

However, in 1999 the Health Act gave the Government an order making power to use for all regulatory bodies. Primary legislation could now be amended much more quickly. In July 2000, at the GMC's request, the Government used this power for the first time. More robust powers to suspend doctors on an interim basis (powers the Council did not possess when Harold Shipman was first arrested), together with tougher restoration powers and the ability to hear cases more quickly, using non-GMC members to sit on additional panels, followed.

However, piecemeal alteration of an arcane legislative framework by a governing body of 104 members meeting three times a year no longer fits the bill.

Consequently, in February 2000, the Council launched a fundamental overhaul.

The aim was to build an organisation which could operate effectively and speedily, with input from all key stakeholders and much clearer lines of accountability.

The GMC also made recommendations on the need for its functions as investigator, judge and jury to be separated, in response to the introduction of the Human Rights Act and to meet the desired objective of being seen to be fair.

The Council agreed that the functions should be separated and requested more work on how the separation could be implemented.

In October 2000 a consultation document on the GMC's constitution, structure and governance detailing three options was sent to doctors' professional bodies, patient groups, NHS management, politicians and others. The responses helped the Council to refine its ideas in preparation for formal consultation in 2001.

This enabled a definitive consultative document to be published, outlining the proposals put forward by the GMC and the alternatives. These proposals sit alongside detailed plans for change to the Council's fitness to practise procedures.

The Council's preferred model included:

- A small Board of 20 to 25, with 40% lay membership, statutorily responsible for the discharge of the GMC's four functions – education, standards, registration and fitness to practise, chaired by a medical President.
- A Council of around 50 to 80, with 50% lay membership, statutorily responsible for the election of the Board from its own membership, and considering policy issues, chaired by a lay member.

The formal consultation was launched in March 2001 and lasted six weeks. It was important to receive the views of both the profession and the public on the Council's preferred model and the alternative approaches. The Council was particularly keen to understand the views of all on the different and distinct statutory roles of the two new bodies – the Board and the Council. This was a real opportunity for doctors and the wider public to make their comments known.

The Council will reach final conclusions in May, leading to recommendations to the Government later this year. The aim is to have the new GMC in place as soon as practicable but no timetable has been set because the changes will almost certainly require legislation. Meanwhile, the drive to make the GMC truly fit for purpose continues.



Simplicity
Respect
Trust



Change Cl



GMC reforms

1995 – 1999

- 1995 – Published new standards for the profession – *Good Medical Practice*
- 1996 – Doubled the number of lay members from 12 to 25
- 1997 – Introduced new powers to deal with doctors whose professional performance is seriously deficient – the performance procedures
- 1998 – Proposed a new requirement that all doctors regularly demonstrate they are up to date and fit to practise in their chosen field – revalidation

2000

Published new guidance on confidentiality

Secured:

- more flexible powers for interim suspension
- more robust restoration procedures
- co-opting non-GMC members to fitness to practise committees

Increased hearings of the main fitness to practise committees to process more cases

2001

Delivery of a new look Council

Agree model for revalidation

Agree fitness to practise reforms

Strengthen education role to co-ordinate all stages of medical education

Publish a new edition of *Good Medical Practice*

Implement new integrated registration system

Deliver explicit service standards

Acting when things go wrong

One of the greatest challenges facing the GMC is dealing with the growing number of complaints more quickly while both protecting patients and being fair to doctors.

The GMC has already taken steps to stream-line the process and to strengthen its powers. These incremental changes have delivered improvements in the handling of concerns about problem doctors but the organisation is now up against the limits of what can be achieved within the current framework and is therefore working towards more fundamental change.

Because the process must be fair to both sides it is governed by law and each stage is open to legal challenge. Under our statutory rules at each stage the doctor has to be given adequate opportunity to take advice and respond. Consequently the process takes time.

The GMC must be more transparent in the information it gives to complainants so they have a more realistic expectation of how long it will take to deal with their complaint and why it is being dealt with in a particular way.

Wider new powers

A significant contribution towards enhancing our capacity to protect patients in the last year has been to secure new fitness to practise powers.

The GMC's root and branch review of its procedures was announced in November 1999 when possible options for change were discussed. The review recognised that some changes should be introduced immediately while others require significant new legislation.

Of most concern were the weaknesses in the restoration procedures, anomalies in powers of interim suspension and the backlog of cases awaiting a hearing by the Professional Conduct Committee.

After the GMC raised these issues with the Department of Health, the Secretary of State for Health invited Parliament to use the order-making power (created in the Health Act 1999) to grant the GMC new powers.

The new powers mean:

- Doctors erased from the register cannot apply to be restored for a minimum of five years as opposed to 10 months previously.
- After two unsuccessful applications for restoration the Committee can prevent a doctor from making further attempts.
- No doctor can be restored unless there has been an objective assessment of his or her fitness to practise.
- Interim measures on doctors' registration (either suspension or conditions) are possible at any stage and in all of our procedures. Previously interim orders could only be considered at the Preliminary Proceedings Committee and only in conduct cases. The new Interim Orders Committee sat for 16 days in 2000 and made new orders against 30 doctors.

- By enabling us to recruit non-GMC members to sit on professional conduct committee hearings alongside our existing members we are able to hear more cases, thus helping to tackle the backlog.
- Employers and the Secretary of State are informed when a doctor is referred to the Interim Orders Committee, the Preliminary Proceedings Committee or for a health or performance assessment, improving communication with those who employ the doctors being dealt with.

Dramatic increase in workload

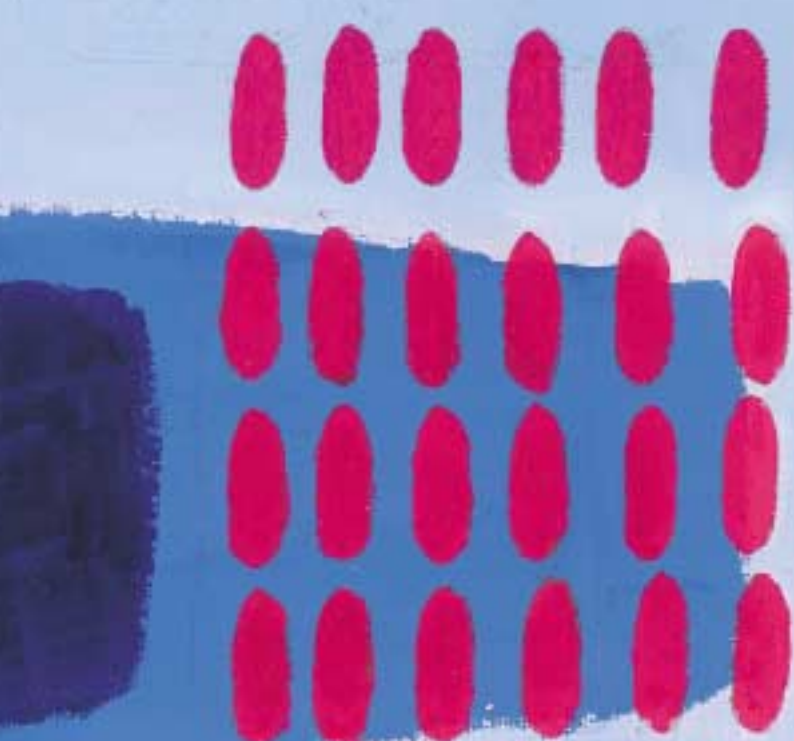
The past year has seen a continued increase in the number of complaints, which increased from 3,000 in 1999 to 4,470 in 2000. This may in part have been due to the GMC's higher profile generally but also a direct response to publicity following particular cases.

The GMC has a very distinct role in handling complaints; it can only take action if the allegations bring into question the doctor's right to practise medicine. A large proportion of complaints do not meet that test because, though serious to those involved, they do not indicate that the doctor is unfit to practise. From July 2000 we have contacted complainants quickly to encourage them to use the appropriate local process. Between July and December 2000, 417 complaints were re-routed in this way.

The past year has seen a continued increase in the number of complaints. Complaints increased from 3,000 in 1999 to 4,470 in 2000.



Clearer
Faster
Better



A priority has been to reduce the amount of time complaints take to consider.

Acting when things go wrong

(continued)

The GMC has worked closely with the NHS and other bodies responsible for dealing with concerns about doctors, including the Commission for Health Improvement, NHS regional offices and the police to ensure that the most appropriate body deals with the concern effectively and that patients are protected.

The increase in workload has also meant an increase in staff in fitness to practise, from 64 to 90 out of a total 241 GMC staff.

Reducing delays

A priority has been to reduce the amount of time complaints take to consider. In July explicit service standards were agreed and by the end of the year the results began to show through.

Before July the initial stages of consideration of cases was very slow with only 40% of complainants getting a decision on whether their case would progress, within six months. In the first six months since July 2000, 81% of conduct case decisions have been made within six months.

Similar pressures were felt by those awaiting Professional Conduct Committee hearings. In December there were 215 doctors waiting. The aim is for no case referred on by the Preliminary Proceedings Committee to wait longer than a year before appearing at the Professional Conduct Committee.

Performance procedures

The year saw a predicted increase in the number of cases being referred to the performance procedures. These were introduced in 1997 to allow the GMC to deal more effectively with doctors who demonstrate a pattern of poor performance. In 2000, 125 performance cases were considered, four times the number considered in 1999.

The future of fitness to practise

By the middle of the year, the Council turned its attention to necessary longer term reforms. This was given increased impetus by the Governance Working Group recommending that the GMC separated various fitness to practise functions for reasons of equity and in order to be seen to comply with the spirit, as well as the letter, of Human Rights legislation.

The issue of whether the criminal or civil standard of proof should remain for all GMC procedures has been under consideration for some time and was echoed in the NHS Plan, published in July 2000. In December 2000, following publication of an issues paper prepared by the King's Fund, the GMC convened an expert conference to explore this issue. Hosted by the King's Fund the conference was chaired by Lord Lester QC, renowned expert in human rights issues.

It marked a new approach for the GMC in developing constructive partnerships with key stakeholders to address important issues.

The results of the conference were considered by the Council in February 2001 along with a package of proposals for revision to the early stages of handling a complaint, dealing with concerns which fall just below serious professional misconduct or seriously deficient performance, the most appropriate standard of proof for cases where erasure is not being considered and the separation of functions within the fitness to practise procedures.

A consultation period began in March 2001. The results of that consultation will be considered by the Council throughout the course of 2001.

Major changes are on the way within the GMC's fitness to practise directorate, changes which will ensure fairness, transparency, objectivity and freedom from discrimination. These are principles to which the Council is committed and which they intend to deliver to ensure that both patients and doctors have confidence in the process.

Your decision

“...we no longer live in an era when decisions are made for patients, but one in which decisions are made with patients.” Chief Medical Officer for England

When the parents of children who had died at Alder Hey gathered at a national summit, convened by the chief medical officer for England, there was a deep and common cause for concern. There were serious questions to be asked on whether parents had been adequately informed of what was happening to their children. Questions as to whether they had been a part of the decisions made for their children.

The chief medical officer chose his words well when he said at the opening of the summit that we no longer live in an era when decisions are made *for* patients but one in which decisions are made *with* patients. They were words which were met with heartfelt agreement at that meeting.

This understanding of the doctor/patient relationship as a partnership is at the heart of the GMC's guidance on consent¹. The opening paragraph states that patients must be given sufficient information, in a way they can understand, in order to enable them to exercise their right to make informed decisions about their care. No one may make decisions on behalf of a competent adult. The process of obtaining that consent cannot be an isolated event. It is a continuing dialogue, keeping patients abreast of changes in their condition and the treatment proposed.

In the guidance there are suggestions on how information which a patient might find difficult to understand, or distressing to know, can be conveyed thoughtfully and effectively. The particular difficulties which can arise in seeking consent for interventions with children, or where adult patients lack capacity to make their own decisions, and in areas such as screening and research, are also covered. The emphasis throughout is on achieving open, helpful dialogue with patients and those close to them involved in making decisions about their care.

The importance of consent is conveyed to doctors early in their training. Undergraduates are introduced to *Good Medical Practice*² and the professional values and standards set out in the GMC's other guidance booklets³. Many medical schools have developed professional and personal development strands, which run throughout all undergraduate education and training. This involves dedicated teaching and learning sessions on seeking consent, and often include role plays and discussions of 'consent' scenarios and the ethical and legal issues which they raise. Guidance is issued by others too, such as a doctor's employer.

In a year when the importance of this issue became a significant news story, the most prominent case concerning consent in 2000 was the one concerning the Siamese twins born in Manchester. There, against the expressed wishes of the parents, the courts determined that doctors could operate on the twins in their endeavours to save the life of one of them. The issue of consent is not always easy to resolve. This was a reminder that, in the case of children who lack capacity to decide for themselves, and where serious disagreement about what course of action is in the child's best interests, ultimately society has authority to decide.

During 2000 the GMC issued guidance to doctors on confidentiality. This included a clear reference to the need to obtain patients' consent when passing confidential information to a third party. This is a requirement of common law and data protection legislation. But it was seen by some as a threat to the work of the cancer registries, which believed that the need to obtain consent would prevent doctors from passing comprehensive information to them. They argued that informing patients and seeking consent put an unacceptable burden on doctors, which would lead to data not being transferred to registries.

There is little doubt that patients are happy for information to be passed on but the GMC takes the view that there is a need for them

to know and give their consent – unless society, through Parliament, decrees otherwise and determines that the public interest should override an individual's rights.

The Health and Social Care Bill was used to help resolve this issue by enabling the Secretary of State to issue regulations to allow the disclosure of confidential information in specific circumstances, 'when in the public interest or in the interests of patient care'. The GMC supported this in the case of cancer registries but did have doubts about the scope of the legislation, as it was first drafted. In that form it would have enabled a future Secretary of State to issue much wider directives about what might be disclosed. This seemed to reverse the trend towards giving the patient greater control and the right to consent. A campaign undertaken by the GMC to protect patient rights, resulted in the Government introducing a series of safeguards to protect confidentiality.

The Health Minister, John Denham, announced that regulations on waiving confidentiality would be introduced following advice provided by an advisory committee, which would consider the criteria under which exceptions on informed consent might be considered.

The advisory committee will provide advice to the Secretary of State and that advice will be published. Additionally, following significant campaigning it was agreed that the regulations will be revisited annually to see whether they are still necessary – for instance, whether anonymous data could be introduced instead.

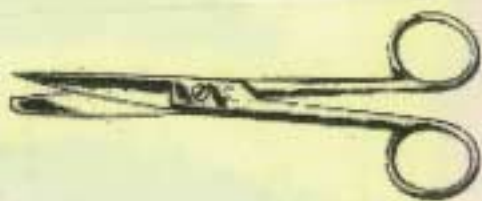
There is a strong consensus on consent but some specific issues need to be debated further.

1 Seeking patients' consent: the ethical considerations, published 1998

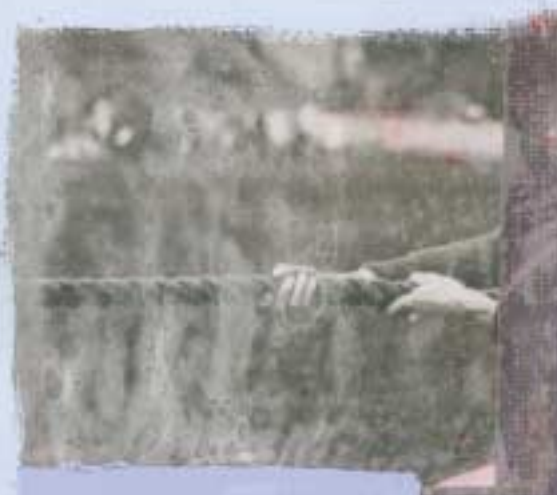
2 Issued by the GMC

3 Seeking Patients' Consent: the ethical considerations; Confidentiality: Protecting and Providing Information

Push me Pull you



Choice

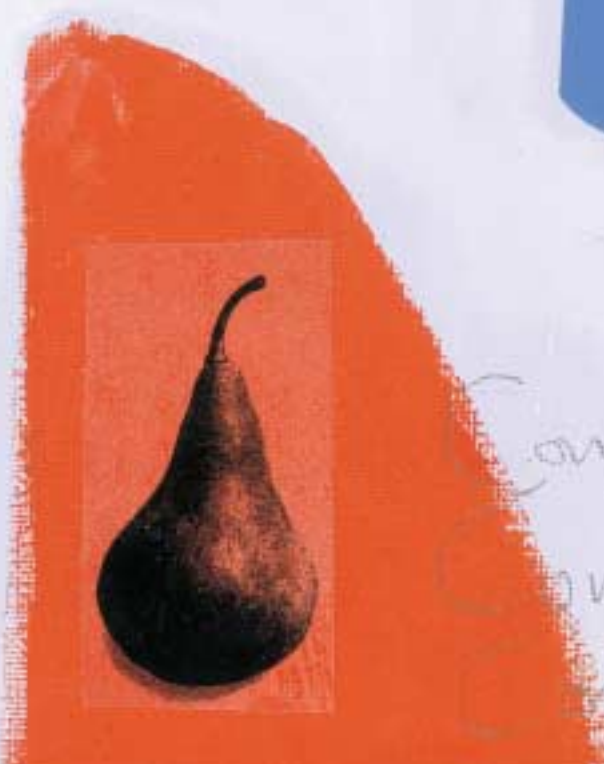




take My hand...



Trust Me



Confidence
Confidence
Confidence



Earning patients' trust

As we become a more informed society, so we demand more information about and influence upon almost every factor to impact upon our lives.

Trust is at the heart of the doctor patient relationship. Despite the criticisms and media attacks on the medical profession in the past year, doctors continue to be held in high regard. But while the trust patients have in their own doctors has been maintained there is suggestion that the public have less confidence in the profession as a whole. On the other side, doctors feel vulnerable to complaints and low morale is widely reported.

All this is not entirely because of the cases that have been brought before the courts or the GMC. Society has changed. It is now less willing to trust, without that trust being earned. As we become a more informed society, so we demand more information about and influence upon almost every factor to impact upon our lives. When individuals are let down they want to know why and be given an assurance that everything will be done to prevent it from happening again. The rise of consumerism is a reflection of this trend.

Doctors are not exempt from this trend. The public expects them to earn their trust, rather than take it for granted. They should be well trained and up-to-date; and be able to show their continuing fitness to practise – including an ability to communicate well with patients.

For the GMC, as for many regulators, this has led to a shift in emphasis towards better quality assurance. It is not enough to ensure that those who enter the register meet the required standards and that action is taken against those on the register who breach those standards. Most people will be happy to accept that registration indicates a doctor's competence at the time of first registration but they want to know more than that. A doctor's continuing professional competence is now equally important for patients, if they are to retain trust in the profession.

The development of revalidation by the GMC is a critical part of this process. It is intended to complement local quality assurance, so that problems in a doctor's performance are detected early and remedied well before the question of the doctor's revalidation arises. The GMC's proposal is that every doctor should prove their continuing fitness to practice through the revalidation process every five years.

Revalidation will also be important in raising the perception of the GMC as a centre of quality assurance: building up expertise in education, assessments such as that undertaken by the Professional and Linguistic Assessment Board (PLAB), the development of performance procedures and soon the establishment of panels to undertake the revalidation process.

The principle of revalidation has been accepted by most, but the method of implementation has been a concern to doctors, leading to concerns about revalidation as a practical proposition. The GMC takes the view that the principle of revalidation has been accepted. Society, and particularly government, want regulators to provide this level of quality assurance. The GMC is confident that concerns can be addressed and an agreed formula implemented.

The GMC is committed to ensuring that revalidation is achieved in the most economic and efficient manner. The annual appraisals to be instituted by the NHS will provide important information for revalidation.

A pilot scheme and an economic evaluation have been implemented so that decisions on the shape of revalidation are made in May 2001. Legislation will then be required, following which there will need to be further planning and preparation for implementation. The first tranche of doctors to be revalidated will then require a reasonable period for which to present the quality of data that will be required. This suggests that the first revalidation will take place at least 12 months following the passage of legislation through Parliament.

Members of the General Medical Council

1 January 2001

President

Sir Donald Irvine CBE

Members elected for the constituency of England, including the Channel Islands and the Isle of Man

Karim Admani OBE JP
Sir George Alberti
Munther Al-Doori
John Anderson
Rachel Angus
James Appleyard
Bhanu Bhanumathi
Liz Bingham
Edwin Borman
Cecilia Bottomley
Stephen Brearley
Dame Fiona Caldicott DBE
Sir Cyril Chantler
John Chisholm
Naginah Choudhuri
Jennifer Colman
Caroline Doig
James Drife
Andrew Fergusson
Simon Fradd
Alex Freeman
Brian Goss
Pearl Hettiaratchy
Sir Barry Jackson
Alam Khan JP
Krishna Korlipara
Surendra Kumar
Sir Alexander Macara
Sola Oni
Shiv Pande MBE JP
Sir Denis Pereira Gray OBE
Rosalind Ranson
Peter Richards
Wendy Savage
Akram Sayeed OBE
Robert Slack
Andrew Stewart
Hilary Thomas
Nicola Toynton
Fay Wilson
Michael Wilson
Ronald Zeegen

Members elected for the constituency of Northern Ireland

Chitra Bharucha
Jack McCluggage

Members elected for the constituency of Scotland

Douglas Gentleman
Brian Keighley
Richard Kennedy
Arnold Maran
Fiona Pearsall
Ann Rennie
Anthony Toft CBE

Members elected for the constituency of Wales

Malcolm Lewis
Nigel Stott
Jane Wood

Appointed members representing undergraduate licensing bodies

Colin Bird CBE
Graeme Catto
Universities of Aberdeen, Dundee, Edinburgh and Glasgow

Robert Stout
Queen's University of Belfast

Peter Rubin
Frank Woods
Universities of Birmingham, Leicester, Nottingham and Sheffield

Deborah Sharp
Universities of Bristol and Southampton

Sir Colin Berry
Robert Boyd FRCP
Ken Hobbs
University of London and Society of Apothecaries

Robert Dickson
Universities of Leeds and Newcastle

Joan Trowell
Universities of Oxford and Cambridge

Roger Green
Universities of Manchester and Liverpool

Ian Cameron CBE
University of Wales

Appointed members representing Royal Colleges and Faculties

David Snashall
The Faculties of Public Health Medicine and Occupational Medicine

David Hatch
The Royal College of Anaesthetists

Sir Donald Irvine CBE
The Royal College of General Practitioners

Lord Patel
The Royal College of Obstetricians and Gynaecologists

Jeffrey Jay
The Royal College of Ophthalmologists

Norman MacKay CBE
Averil Mansfield CBE
James Petrie CBE
The five Royal Colleges of Physicians & Surgeons of England and Scotland

Sheila Mann
The Royal College of Psychiatrists

Sir Roddy MacSween
The Royal Colleges of Radiologists & Pathologists

Appointed member representing nominating bodies not otherwise represented on Council
Denis McDévvitt

Lay Members nominated by Her Majesty the Queen, on the advice of Her Privy Council

Rani Atma
Kevin Barron MP
Colin Breed MP
Mary Clark-Glass CBE
Manny Devaux JP
Roland Doven JP
Baroness Emerton DBE
Ruth Evans
The Very Reverend Graham Forbes
Sue Leggate
Lea Macdonald
Angela Macpherson
Humfrey Malins CBE MP
Campbell Morton
Arun Midha JP
Rabbi Julia Neuberger
Robert Nicholls CBE
Christopher Robinson CBE
John Shaw CBE
Douglas Smyth OBE

Lady Tumim OBE JP
Eileen Walker
Gareth Wardell
Bob Winter
Rodney Yates

The Chief Medical Officers are not members of the GMC but attend meetings of the Council in full session

Henrietta Cambell CB
Chief Medical Officer for Northern Ireland

Mac Armstrong
Chief Medical Officer for Scotland

Liam Donaldson OHP
Chief Medical Officer for England

Ruth Hall
Chief Medical Officer for Wales

Treasurers

Ian Cameron CBE
Shiv Pande MBE JP

Chief Executive and Registrar
Finlay Scott TD

Directors

Annette Bridgman
Personnel and Development

Andrew Ketteringham
Communications

Bruce Minty
Finance and Business Systems

Isabel Nisbet
Fitness to Practise

Carol Stone
Registration

Antony Townsend
Standards and Education

Committee Chairmen



Sir Donald Irvine
Chairman PAC
Chairman PCC



Professor Graeme Catto
Chairman EC



Professor Ian Cameron
Chairman &
Treasurer FEC



Dr Shiv Pande
Treasurer FEC



Mr Stephen Brearley
Chairman RC



Dr Antony Toft
Deputy Chairman RC



Professor Frank Woods
Chairman HC



Dr Jane Wood
Deputy Chairman HC



Professor David Hatch
Chairman CPP



Baroness Emerton
Deputy Chairman CPP



Miss Alam Khan
Deputy Chairman CPP



Miss Caroline Doig
Chairman ARC



Professor John Anderson
Deputy Chairman ARC



Mr Rodney Yates
Deputy Chairman ARC
Chairman FPPC



Professor Ken Hobbs
Deputy Chairman PCC



Professor Peter Richards
Deputy Chairman PCC



Mr Robert Nicholls
Chairman PPC



Professor Sir Roddy MacSween
Deputy Chairman PPC



Professor Sir Cyril Chantler
Chairman SC



Mrs Angela Macpherson
Chairman IOC



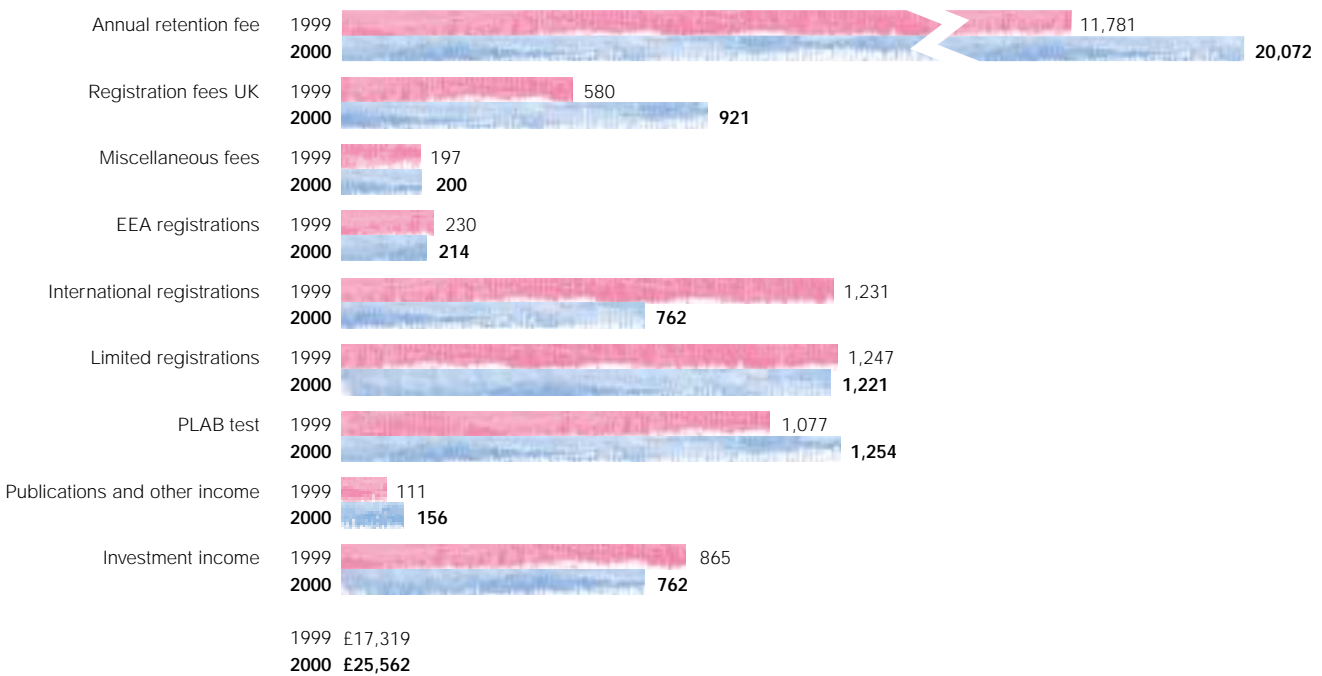
Professor Norman MacKay
Deputy Chairman IOC

ARC Assessment Referral Committee
CPP Committee on Professional Performance
EC Education Committee
FEC Finance and Establishment Committee
FPPC Fitness to Practise Policy Committee
HC Health Committee
IOC Interim Orders Committee

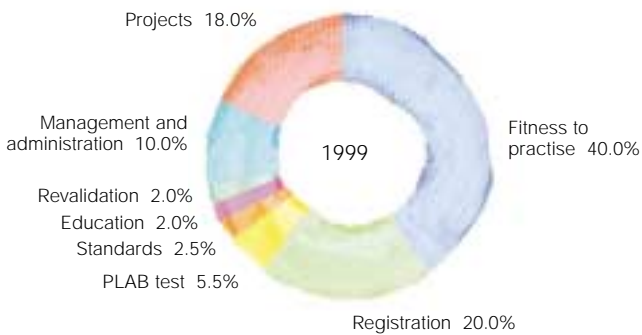
PAC Presidents Advisory Committee
PCC Professional Conduct Committee
PPC Preliminary Proceedings Committee
RB Review Board for overseas qualified doctors
RC Registration Committee
SC Standards Committee

Income and expenditure analysis

Income (£000s)

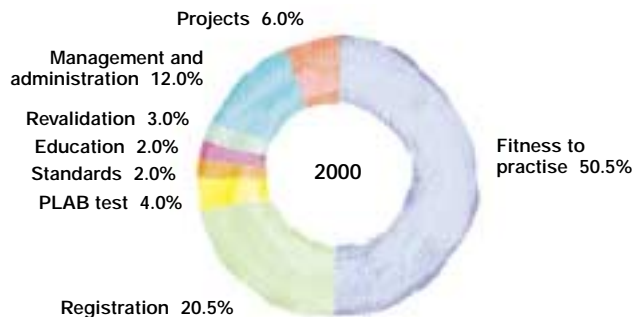


1999 Expenditure (%)



Total expenditure 1999 £19.5m

2000 Expenditure (%)



Total expenditure 2000 £27.3m

Useful GMC numbers

Checking a doctor's registration

Telephone 020 7915 3630

Fax 020 7915 3532

GMC publications

Telephone 020 7915 3507

Fax 020 7915 3685

The GMC and medical education

Telephone 020 7915 3493

Fax 020 7915 3599

Fitness to practise inquiries

Telephone 020 7915 3603

Fax 020 7915 3642

Health procedures

Telephone 020 7915 3580

Fax 020 7915 3680

Performance procedures

Telephone 020 7915 3667

Fax 020 7915 3680

Inquiries about standards and ethics

Telephone 020 7915 3568

Fax 020 7915 3599

Main switchboard and fax

Telephone 020 7580 7642

Fax 020 7915 3641

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 right 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.