Maintaining pace: setting the agenda

The General Medical Council in 2002

President’s foreword
• The new GMC

Review of 2001
• Important developments

Structure and governance
• Consultation and consensus

Revalidation
• Quality assurance

Fitness to practise
• Fairness to patients and doctors

Channels of communication
• Better connections

Guiding doctors
• Ensuring proper standards of practice

The safe care of patients is at the heart of everything we do
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earning the trust
of the public and the profession by being
more open, accountable and responsive
The last few years at the GMC have been somewhat turbulent. Criticised by doctors for being out of touch with the profession and by the public for not representing sufficiently clearly their interest, there have been times when we have felt pretty friendless.

In my view the criticisms have not all been valid – although I acknowledge that the GMC was slow to recognise the need for change. Society had been changing rapidly but we had not. So the GMC was fortunate when it elected its last President, Sir Donald Irvine, that it had identified someone who recognised the need for reform. Donald spent his entire period in office charting the changes that were needed. At the Council meeting before he retired, one of our members summed up the impact of Donald’s work. Admitting that we had not yet fully re-established the confidence of the public or indeed the profession, he said: “One thing I am quite sure of is that we have not won the battle yet, but if it hadn’t been for Sir Donald we would have lost it”. I endorse that and thank Donald for his commitment to the GMC, particularly in his six years as President. These were difficult years that needed foresight, fortitude, integrity and determination. He has all of those qualities.

Nor have I any doubt that the battle would have been lost without our carefully laid plans to reform the governance, systems and culture of the GMC. We have drawn up the blueprint for reform. Legislation is about to enact the changes that are needed and we must now implement those changes to ensure the GMC has the trust and confidence of both the public and the profession.

The purpose of the GMC is to protect patients. Like any other regulator we are there to act in the public interest. The manner in which we do so is a partnership. That partnership is professionally led and in the new GMC doctors will continue to be in a majority. But the degree of involvement by lay members is critical to making it clear that the patient is at the heart of everything we do.
This review describes the changes that we are poised to make: reducing the size of our Council and increasing the proportion of lay members; streamlining our procedures for dealing with complaints against doctors; and introducing a system to check the fitness to practise of doctors throughout their working lives. It’s an enormous programme of work. We will need support in implementing it from the profession and from others involved in the regulation of medicine. Regulation has become a complex matter with many different bodies involved, each with a specific remit. I want to make sure that the GMC works well within that network but at the same time ensure that patients and doctors understand how we operate and how we relate to them. A measure of our success in the coming year will be the way we present ourselves to the public and gain their trust.

Of course, we cannot fulfil our principal responsibility to patients without the support of the profession. The GMC must be a listening body. The scandals and criticism of recent years have sapped the self-confidence of the profession. One of my tasks is to restore a proper sense of self-esteem by leading the GMC in a manner which both has doctors’ support and meets the expectations of society.

Many of the problems we have experienced in the last few years are also encountered in other countries. I welcome the increasingly open and informed public debate over the future of our health services and believe that we have much to contribute to a greater understanding of the ways in which the government, public and profession can co-operate to ensure high standards of patient care. We protect patients by guiding doctors through education and agreed standards. I do not underestimate the difficulty of my task in restoring the confidence of the public and the profession in the GMC. It will be made easier by having new structures that are fit for purpose. I look forward to reporting to you on the progress that we have made.

Sir Donald Irvine
Outgoing President

Sir Graeme Catto
President
Review of 2001

2001 was an important year for the GMC. In June the Charity Commission recognised our charitable status, and defined our purpose as: ‘The protection, promotion and maintenance of the health and safety of the community by ensuring proper standards in the practice of medicine’.

This review of 2001 looks at the ways in which we have fulfilled our charitable purpose in each of our four areas of responsibility, and ways in which they will evolve in future as we implement our reform programmes. We are determined that the GMC of the future will meet the community’s needs and will merit and maintain the confidence of the public and the profession.

Registration

One of the major planks of our reform programme is the introduction of revalidation, which will require doctors to demonstrate that they remain up-to-date, and fit to practise; and will ensure that the register has a new integrity.

Meanwhile, we have redesigned our registration processes and developed a new IT system to support them. Our aim is to secure a significant improvement in customer service, effectiveness and efficiency, and in our capacity to go on improving. We initially experienced a number of problems with changing from the old to the new systems, and, as a result, for a period failed to deliver acceptable levels of service to doctors and employers. We have worked hard to resolve the problems; and are confident that the systems now bedded in will deliver greater opportunities for generating operational efficiencies.

We have continued to look for ways of meeting the needs of overseas qualified applicants. PLAB Part 1 tests are now held in Egypt, India, Nigeria, Pakistan and Sri Lanka; and we are exploring the feasibility of establishing a test centre in Bulgaria. Candidate numbers for the test continue to be high, 2001 showing an increase of some 50% over 2000.

We announced an increase in the annual retention fee from 1 January 2002, which we were aware came as unwelcome news. The increase was principally due to the continued rise in the costs of our fitness to practise procedures, which totalled almost £20m in 2001 compared with just over £16m five years ago.
We are looking for further economies and during the year we have made savings of £2m. We have reviewed our accommodation options and, as described elsewhere, plan to move some activities outside London.

**Medical education**

When the first edition of Tomorrow’s doctors was published in 1993, it reflected a radically new approach to undergraduate medical education. It focussed on the importance of equipping students with the knowledge, skills and attributes they needed to begin work effectively and to go on learning and adapting to changing circumstances. The recommendations were widely welcomed and proved influential in changing attitudes to medical education in the UK and abroad.

We have been working on a new edition of Tomorrow’s doctors, which will be published in Summer 2002. The main thrust of the guidance will not change. It will, however, be brought up-to-date and augmented to reflect issues that have come to prominence since the first edition, such as the legal and ethical basis of medicine, multi-professional working, and the preparation of students for practice in a multi-cultural society. One significant development will be the explicit linkage of the guidance with the principles set out in Good medical practice, which had not been published when Tomorrow’s doctors first appeared.

Over the past six years we have been monitoring medical schools’ progress towards implementing the recommendations in Tomorrow’s doctors; and the programme of informal visits was completed in 2001. We began a programme of work in relation to the four new medical schools recently authorised by the government; and started to plan for the future quality assurance of basic medical education. We have also begun a review of our guidance to medical schools on student health and conduct.

We have also been exploring how we might develop our educational role, and how we might work more effectively with our partners, particularly the Royal Colleges, to fulfil our statutory responsibility to co-ordinate all stages of medical education. We have agreed to establish a series of advisory boards under the auspices of the Education Committee that will cover the main phases of medical education, including specialist training and continuing professional development. We look forward to working with others on the development of the future Medical Education Standards Board, which will supervise postgraduate medical education.

**Fitness to practise**

As we reported last year, we have embarked on a root and branch review of our fitness to practise procedures.

In 2001, we received some 4,500 new complaints against doctors – an increase of just under 1% on 2000. We resolved about 5,300 complaints, an increase of just under 38% on 2000.

The number of cases awaiting a Professional Conduct Committee (PCC) hearing remains high and we are continuing with our programme of increased sitting days. PCC panels sat for 479 days in 2001, as opposed to 242 in 2000; and the Interim Orders Committee (IOC) for 95 days. We have appointed 150 non-GMC members to serve on our fitness to practise cases; and taken on new committee accommodation to enable more panels to meet in parallel.
the GMC of the future will meet society’s needs and will merit and maintain public confidence.
Medical ethics and standards of practice

We set the standards of professional practice by describing what is expected of doctors, in their day to day conduct and performance, by the profession and by society.

The first publication of Good medical practice, in 1995, marked a radical move towards the development of explicit, generic principles of practice. A new edition was published and distributed to all doctors in August 2001.

The principles of Good medical practice inform the guidance in the new edition of Tomorrow’s doctors. They will provide the template against which doctors’ continuing registration will be regularly revalidated in future and are the foundation of fitness to practise findings. They underpin all our work and are at the heart of our commitment to the safe care of patients.

The new edition of Good medical practice takes into account comments and suggestions received from individuals and organisations. It provides updates where necessary, and ensures that the standards and principles against which doctors will be revalidated are clear by reorganising the guidance using the headings under which doctors are expected to be assessed during revalidation and NHS appraisal.

We have also revised the booklet Confidentiality: protecting and providing information to reflect the changes in the law introduced by the Health and Social Care Act 2001, and the different legal frameworks in Scotland and Northern Ireland. We worked hard to ensure that the new arrangements strike an appropriate balance between patients’ rights and the need for data for research and epidemiology. We will reissue the guidance when the provisions of the Act come into force.

Work progressed on our guidance on withholding and withdrawing life-prolonging treatment. This included a large public consultation exercise that drew more than 700 replies; and a small workshop-based conference which proved particularly beneficial in engaging our partners in debate on this most fundamental of issues. A final version of the guidance is expected to be ready in Summer 2002.

We responded to the need for clearer guidance on the difficult area of medical research; and our new booklet was published and distributed to all doctors early in 2002. The issues covered include seeking consent; involving vulnerable adults and children in research; the responsibilities of doctors managing research; confidentiality; and using and retaining organs and tissues. The guidance sets out the ways in which public trust can be maintained through honesty and openness, and how partnerships can be made and sustained through respect for participants.

A revised version of the guidance on undertaking intimate examinations has been completed, prompted by some common problems seen in complaints made to us about doctors. Work on reviewing the guidance Making and using visual and audio recordings of patients is also in hand.

Infrastructure

We have continued to develop a framework for our constitution, structure and governance which is fit for purpose and which will enable the efficient delivery of our reform programme. Our underlying principles are that effectiveness, inclusiveness, transparency and accountability must be evident in all aspects of the GMC’s work.

The international community

We have continued to play a leading role in international exchange and debate; to provide technical assistance to countries, such as Albania, which are in the throes of setting up new regulatory systems; and to work towards the establishment of the International Association of Medical Regulatory Authorities. IAMRA’s primary purpose will be to facilitate the exchange of information on migrating doctors: a major initiative aimed at ensuring patient safety across the globe.
The reformed Council

At the heart of the discussions lay the size of Council and the distribution of seats. We reached a consensus around a Council of 35 members with statutory responsibility for discharging the GMC's functions comprising:

- 19 elected medical members
- two appointed medical members (to be appointed by the Academy of Medical Royal Colleges and the Council of Heads of Medical Schools)
- 14 lay members (to be appointed through a more transparent process).

There will also be an overhaul of the arrangements for electing doctors to the GMC. 150 doctors and members of the public have been appointed, through open selection, to sit on conduct and other hearings alongside Council members. The reduction in the number of Council members will increase our need to recruit more non-council members to help us with our work.

Reform through consultation and consensus

By the end of 2002 there will be legislation to support the implementation of the widest and most radical review we have undertaken of our structure and governance since the Merrison inquiry. The review addressed multiple aims across the organisation. The remit was to design a more accountable and transparent organisation which could operate effectively and responsively with the inclusion of key stakeholders. A Council of 104 members is too large and unwieldy for effective decision making at the pace required today, and too small to provide all the people needed for smooth operation of the GMC’s work. The reform process began by identifying principles to underpin the organisation’s aims:

Effectiveness - the need for the GMC to discharge its statutory functions as effectively as possible

Inclusiveness - the need for the GMC to have the confidence and participation of all key stakeholders

Accountability - the need for the GMC to account to its stakeholders, to enable them to judge and to have confidence in its performance

Transparency - the need for the GMC to be open about the decisions and actions it takes.

The next step was extensive consultation. In October 2000 a preliminary consultation paper describing three options for change was sent to doctors, their professional bodies, patient groups, NHS managers, politicians and the media. By the end of the year, and taking into account response to the preliminary consultation, we were clear about how the new Council should look.

In March 2001 we published a definitive consultative document. The Council's preferred option was for a two-tier structure, with a body large enough to secure inclusiveness, acting as an electoral college for a smaller statutorily-empowered Board, which would secure effectiveness. This approach did not convince many stakeholders, who were concerned about tension between the two tiers. Other approaches failed to resolve the inherent conflict between inclusiveness and effectiveness, so in June 2001 we held a consultative conference to break the log-jam.

The conference worked. Key professional and consumer groups were able to sign up to a new formula put forward by the GMC. They agreed that:

- there should continue to be an overall majority of elected medical members on the GMC, in keeping with the principle of professionally-led regulation
- there should be a significant increase in the proportion of lay members, in keeping with the principle that professionally-led regulation is in partnership with the public
- there should continue to be appointed medical members on the GMC
- there should continue to be a statutory Education Committee
- the GMC’s accountability to the public and the profession should be strengthened, and should include more explicit accountability to Parliament, while recognising the role of devolved government in the UK.

The reformed Council

150 ordinary doctors and members of the public have been appointed, through open selection, to sit on conduct and other hearings alongside Council members.

Current Council
- 104 members
- 54 elected doctors
- 25 appointed doctors
- 25 lay members

Reformed Council
- 35 members
- 19 elected doctors
- 2 appointed doctors
- 14 lay members
effectiveness
inclusiveness
accountability
transparency
doctors and patients will benefit from revalidation
Quality assurance: the role of revalidation

The GMC protects patients by maintaining an effective register of doctors who are fit to practice. The introduction of revalidation will ensure that, in future, the register will reflect more accurately doctors’ continuing fitness to practise and will be an important part of their accountability to patients and the wider public.

Of all the elements of the GMC’s reform programme, revalidation will have the greatest impact for both the profession and the patient.

Traditionally, doctors have kept themselves up-to-date voluntarily, but in a changing world, society demands a more robust and effective system to ensure that a doctor is fit to practise. While the current medical register entry indicates doctors’ competence when they are first registered, it may no longer adequately reflect their continuing fitness to practise. Patients need to be able to trust their doctors and revalidation – through the regular testing of a doctor’s continuing ability – will be an integral part of the process of earning this trust.

Doctors and patients will gain from revalidation. Doctors will have a regular review of their own professional development, help in demonstrating that they are giving good medical care, and support in becoming even better. Revalidation will also enable them to identify and correct any weaknesses they may have and give them the opportunity to affirm their own professional good standing. As a consequence, patients will have the reassurance that doctors who have been revalidated have been through a rigorous process to ensure their continued fitness to practise.

Since May 2001, when the GMC asked the government to begin putting the legislative framework for revalidation in place, a great deal of progress has been made, particularly in allaying the concerns that revalidation would involve duplication with other local quality assurance arrangements such as NHS appraisal systems.

In February 2002, agreement was reached on GP appraisal, following earlier agreement reached for consultants, and other public and independent healthcare sectors are also developing their own appraisal processes. In addition, the medical Royal Colleges and Faculties are developing guidance on the standards to be met to demonstrate fitness to practise within a specialty and the types of supporting information that can be used by doctors.

Progress has also been made in defining transitional arrangements for revalidation and developing a strategy to communicate the important link between appraisal and revalidation effectively to doctors. In partnership with the Department of Health and working with the Academy of Medical Royal Colleges and the BMA, the GMC will establish a single authoritative source of information and guidance to support doctors in collecting, storing and submitting information for appraisal and revalidation.

As part of the work to test the different parts of the revalidation process, the GMC is developing and piloting peer and patient questionnaires that will assist doctors to demonstrate their fitness to practise in terms of working relationships with patients and colleagues. In September 2002, a larger scale piloting process will test the reliability of the entire revalidation mechanism.

Through revalidation, the GMC will maintain one list of all doctors who are qualified medical practitioners and whose good standing is recognised. This list will name doctors who are participating in revalidation and who, as a consequence, are granted a ‘licence to practise’ by the GMC. In time, only those doctors holding a licence to practise will be able to exercise any of the privileges currently associated with registration, such as prescribing.

Of all the reforms proposed as part of the GMC’s reform programme, revalidation will have the greatest impact for the profession and the patient.

Draft legislation will be published for consultation in the summer and finalised legislation is expected to be in place by the end of the year.

The first doctors to be revalidated will submit their information folders to the local revalidation group about two years after legislation is passed. Doctors will need to accumulate sufficient evidence about their practice for a revalidation decision to be meaningful. GMC piloting has demonstrated that doctors can collect information about their practice within a reasonable time, and that decisions can be made based on this information.
The GMC has significantly enhanced its fitness to practise powers in recent years. Performance procedures to assess doctors’ competence and clinical performance have been introduced, the minimum period of measure for serious professional misconduct has been increased and it is now possible to suspend or restrict a doctor’s registration promptly pending the outcome of an investigation. But as the volume of complaints and referrals trebled, resulting in some serious delays, our processes were exposed to intense public scrutiny.

Despite important initiatives including the introduction of standards of service and a much more customer-focused approach, the procedures were still taking too long, were too complex and did not command the confidence of the public or the profession.

Consequently we undertook a fundamental review of fitness to practise. This is the third element, alongside revalidation and governance, of the package of reforms we have put to government. The review has been forward-looking, anticipatong a new framework for medical regulation with revalidation in place, engaging with doctors continually, not just episodically with some. Regular appraisal and new national quality assurance organisations (including, in England, the National Patient Safety Authority and the National Clinical Assessment Authority) will be fully operational.

The review has been modelled around six themes:

1. **Separation between the functions of ‘investigation’ and ‘adjudication’**
   - There will be a clear distinction between those who investigate concerns about doctors and prepare the GMC’s case as ‘prosecutor’ and the panels that hear cases. The ‘adjudicator’ function will still fall within the broad ambit of the GMC but will be at arms’ length from it. It will be carried out by Fitness to Practise Panels, which will be smaller than current committees. Members of the new Council of 35 will not be eligible to sit on any adjudication panels. A process of pre-hearing case management will be introduced, legally supervised and involving earlier exchanges of evidence and time-tabling. Hearings will be shortened, as evidence will be available to panel members before the case starts, and there will be no necessity for it to be read into the record. Performance hearings have already shown the benefits of such preparation.

2. **Investigation and speeding up our processes**
   - Investigation will become a single stage rather than a three-stage process. The Committee will delegate functions, both to staff who will refer complaints to the most appropriate complaints mechanism when the concerns they raise are clearly not appropriate for the GMC, and also to ‘Case Examiners’, professional decision-makers from a variety of backgrounds some of whom will be medically qualified.

3. **Streamlining and speeding up our processes**
   - The ‘adjudication’ function will still fall within the broad ambit of the GMC but will be at arms’ length from it. It will be carried out by Fitness to Practise Panels, which will be smaller than current committees. Members of the new Council of 35 will not be eligible to sit on any adjudication panels. A process of pre-hearing case management will be introduced, legally supervised and involving earlier exchanges of evidence and time-tabling. Hearings will be shortened, as evidence will be available to panel members before the case starts, and there will be no necessity for it to be read into the record. Performance hearings have already shown the benefits of such preparation.

4. **Linking responsibly with wider systems of quality assurance**
   - More effective procedures for linking into local medical regulation processes are being developed. This involves greater contact with Trusts or Health Authorities in order to establish whether a complaint represents an isolated incident or is part of a wider concern about the doctor in question, together with building a close working relationship with the new national quality assurance organisations.

5. **Responsibility proportionately to concerns which fall short of the most serious**
   - There is strong support for the idea that, the GMC should have a facility to deal with cases where a doctor’s actions fall short of good practice but not so seriously as to call registration into question.

A holistic approach to fitness to practise

The foundation of fitness to practise findings, as of revalidation and other functions of the GMC, will be Good medical practice. Adjudication panels will ask a single question: whether the doctor’s fitness to practise is impaired by reason of misconduct, poor performance or ill-health to a degree requiring action on registration.

Panels will no longer be restricted by separate concepts for separate processes (for example, ‘serious professional misconduct’) which have historically defied definition, but will be able to ask for different kinds of evidence depending upon the concerns that arise.

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5. **Responsibility proportionately to concerns which fall short of the most serious**
   - There is strong support for the idea that, the GMC should have a facility to deal with cases where a doctor’s actions fall short of good practice but not so seriously as to call registration into question.
While most such complaints will be more appropriately dealt with at a local level, there will be some to which the GMC will wish to respond formally. The appropriate response in such situations will be for the GMC to issue a warning.

Simpler enabling legislation
Procedures must be flexible and capable of evolving over time and in the light of changing circumstances. To that end it is intended that the primary legislation which sets out the GMC’s powers and responsibilities should be less complex, with as much as possible of the detail in secondary legislation or administrative guidance. This will enable a faster response when change is required.

Next steps
The reform programme will be phased-in as soon as practicable, once the necessary legislation is in place. In the meantime the new arrangements will be piloted and interim changes may be made where legislation permits.
Better connections

In April 2002 the GMC opened its first regional office, in Manchester.

With the growing volume of fitness to practise work in recent years, the Manchester office provides a second national hearings centre for professional conduct cases, and will mean that six cases can be held concurrently. The office will also handle the initial consideration of complaints about doctors which arise in Scotland or in the Northwest or Northern and Yorkshire NHS regions, and some registration processing work.

The development will give the GMC valuable experience of decentralised structures. The Council's overriding aim is to improve service for customers. Plans include commissioning research to evaluate both the effect on service provision and the cost effectiveness of the exercise, and surveying all visitors to the office. We will monitor carefully the way the office works with NHS trusts, the Department of Health and other organisations with offices outside London.

The move is also a clear signal of the Council's wish to forge new connections with those on the ground in the English regions and in Northern Ireland, Scotland and Wales. The old model of remote, highly centralised regulation is not sustainable in today's world. Neither will it be a practical reality under the new, devolved, political structures. And, while we currently have 304 ambassadors drawn from all parts of the UK, that network will reduce when the new, smaller Council comes into being in 2003. It is essential for the Council to have good, clear channels of communication with its stakeholders if it is to earn trust and embody a true partnership between the profession and the public.

To this end, the Council has been developing the role of its branch councils, which group together GMC members in Northern Ireland, Scotland and Wales. It is anticipated that each branch council will host a major event in 2002, aimed at invigorating our connections with the profession, the public, parliamentarians and the press in the home countries. These events will look in depth at the future of medical regulation, and in particular at the implications of devolution. We plan to make these stakeholders' conferences a regular annual event in each of the four national capital cities.

The programme for the communication of revalidation will continue to involve intensive work with local audiences.

In a recent initiative by the Council's Fitness to Practise Directorate, designated members of staff have been given particular responsibility for liaison with individual NHS regions. This has proved beneficial in establishing good working relationships and developing two-way co-operation and understanding.

Following an evaluation of the benefits of the Manchester office, the next step will be to consider whether the Council should establish other offices outside London. Manchester could be the prototype for the future.
forging new connections in England, Northern Ireland, Scotland and Wales
Guiding doctors

Ensuring proper standards of practice; listening and responding to the evolving needs of the community and the profession.

Setting standards

In the words of the Charity Commission, the GMC’s purpose is to protect, promote and maintain the health and safety of the community. Fundamental to achieving this purpose is our role in ensuring proper standards in the practice of medicine. We set the standards of professional practice by describing what is expected of doctors, in their day to day conduct and performance, by the profession and by the community. Good medical practice, and indeed all our guidance, is framed as broad principles, leaving doctors the freedom and flexibility to exercise their professional judgement in the light of the GMC’s view.

trust between doctor and patient is central to a successful professional relationship.
Quality assurance
These standards are the threads which run through and connect all our functions. They inform our guidance on the undergraduate curriculum, reaching both students and the doctors who teach them. They are the foundation of our fitness to practice findings; and they will provide the template for the revalidation process.

Good medical practice is beginning to inform all doctors’ approach to their practice, and is gaining increasing recognition, here and overseas. The Kennedy Report, Learning from Bristol, commented: “Good medical practice is a sensitive account of the duties and qualities of a doctor and crucially espouses a patient-centred approach to healthcare”.

Consensus
It is essential that our guidance has public and professional consensus if it is to be relevant to the realities of doctors’ and patients’ lives, and help build the trust between doctor and patient which is central to a successful professional relationship.

To this end we seek input from a wide range of informed and interested parties while we are developing any given piece of guidance; and consult widely once the guidance has started to take shape.

One of our objectives is to set explicit and clear guidance in areas of uncertainty and concern; and so help doctors make the increasingly difficult and complex decisions they face daily.

We have therefore set out the standards of practice expected of doctors when they consider whether to withhold or withdraw life-prolonging treatments. When we began work, we knew we were tackling one of the most difficult ethical, moral and legal subjects society faces today. We did not seek to provide a simple list of prescriptive answers to these difficult questions; rather to give doctors a clear framework within which they can work to find the best way forward in the very varied circumstances they will face.

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At the same time, the subject gave rise to some of the most thoughtful and considered debate ever heard at Council. Sir Graeme Catto described it as ‘a real privilege’ to have been present.

The final guidance reflects the broad consensus which we believe exists within Council, the profession and the public, about what can be regarded as good practice in making decisions about withholding and withdrawing life-prolonging treatments. Its starting point is that doctors have an ethical obligation to show respect for human life, protect the health of their patients, and make their patients’ best interests their first concern. It acknowledges that prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. It accepts, however, that not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient.

We carried out extensive written consultation, and received over 700 responses from a wide range of organisations and many individual doctors and members of the public. We also held a small consultative conference for healthcare professionals, patient and consumer representatives, legal experts and representatives of religious groups. The conference was particularly helpful in encouraging understanding of the different needs and points of view of doctors, patients, carers and families.

Withholding and withdrawing life-prolonging treatments

Nowhere is this complexity more evident than in the issues raised by patients who are near death or who can be kept alive only by medical intervention. The way health care professionals should treat patients in the last stages of life is an increasingly difficult area. Medical science can do more and more to help people live longer; more active lives. But these very treatments can be invasive and painful, and for those nearing death they may bring no benefits, or may simply prolong the process of dying.

Although other organisations have issued guidance on these issues, in matters as complex and uncertain as those surrounding decision making at the end of life, we believed it essential that the regulatory body – to whom doctors may ultimately be accountable for their actions – establish clear guidelines.

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Withholding and withdrawing life-prolonging treatments: good practice in decision-making will be published in Summer 2002. Its existence, its content and the process by which it came into being are evidence of the way the GMC takes the lead in ensuring proper standards of practice; and listens and responds to the evolving needs of the community and the profession.

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Life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient.

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The final guidance reflects the broad consensus which we believe exists within Council, the profession and the public, about what can be regarded as good practice in making decisions about withholding and withdrawing life-prolonging treatments. Its starting point is that doctors have an ethical obligation to show respect for human life, protect the health of their patients, and make their patients’ best interests their first concern. It acknowledges that prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. It accepts, however, that not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient.

Withholding and withdrawing life-prolonging treatments: good practice in decision-making will be published in Summer 2002. Its existence, its content and the process by which it came into being are evidence of the way the GMC takes the lead in ensuring proper standards of practice; and listens and responds to the evolving needs of the community and the profession.

One of our objectives is to set explicit and clear guidance in areas of uncertainty and concern; and so help doctors make the increasingly difficult and complex decisions they face daily.
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Sheila Mann
The Royal College of Psychiatrists
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The Royal Colleges of Radiologists & Pathologists

Appointed members representing nominating bodies not otherwise represented on Council
Peter Hutton
Deborah Sharp

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Ruth Evans
The Very Reverend Graham Forbes
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Angela Macpherson
Huntley Malini CBE MP
Campbell Moran
Aran Mitha JP
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Christopher Robinson CBE
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Eileen Walker

The Chief Medical Officers are not members of the GMC but attend meetings of the Council in full session
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Chief Medical Officer for Scotland
Henrietta Campbell CBE
Chief Medical Officer for Northern Ireland
Sir Liam Donaldson QHP
Chief Medical Officer for England
Ruth Hail
Chief Medical Officer for Wales

Treasurers
Denis McDowell
Shiv Pande MBE JP

Chief Executive and Registrar
Franty Scott TD

Directors
Andrew Kottingham
Corporate Affairs
Dennis Cantwell
Finance and Business Systems
Paul Philip
Fitness to Practise
Isabel Nibbet
Policy
Amanda Watson
Registration
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Professor Sir Graeme Catto
President
Chairman PAC

Dr Chitra Bharucha
Chairman REDC

Mr Stephen Breenley
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Professor Peter Rubin
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Mr Robert Nicholls
Chairman PPC

Dr Shiv Pande
Treasurer

Professor David Hatch
Chairman CPP

Professor Hilary Thomas
Chairman AC

Professor Frank Woods
Chairman HC

AC Audit Committee
ARCC Assessment Referral Committee
CPP Committee on Professional Performance
EC Education Committee
FEC Finance and Establishment Committee
FPFC Fitness to Practise Policy Committee
HC Health Committee

IIOC Interim Orders Committee
PAC President’s Advisory Committee
PCC Professional Conduct Committee
PPC Preliminary Proceedings Committee
REDC Race Equality and Diversity Committee
RC Registration Committee
SC Standards Committee
Summary financial information

Balance sheet (£000s)

<table>
<thead>
<tr>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangible fixed assets</td>
<td>2,496</td>
</tr>
<tr>
<td>Investments</td>
<td>24,292</td>
</tr>
<tr>
<td>Net current assets/ liabilities</td>
<td>(1,632)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(1,100)</td>
</tr>
<tr>
<td>Net funds</td>
<td>24,056</td>
</tr>
</tbody>
</table>

Income and expenditure (£000s)

<table>
<thead>
<tr>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>25,562</td>
</tr>
<tr>
<td>Expenditure</td>
<td>28,069</td>
</tr>
<tr>
<td>Gains/(losses) on investments</td>
<td>(580)</td>
</tr>
<tr>
<td>Deficit before exceptional items</td>
<td>5,087</td>
</tr>
</tbody>
</table>

Income (£000s)

<table>
<thead>
<tr>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual retention fee</td>
<td>20,071</td>
</tr>
<tr>
<td>Registration fees</td>
<td>1,148</td>
</tr>
<tr>
<td>Provisional + Limited registrations</td>
<td>1,429</td>
</tr>
<tr>
<td>PLAB test</td>
<td>1,254</td>
</tr>
<tr>
<td>Miscellaneous fees</td>
<td>741</td>
</tr>
<tr>
<td>Total income</td>
<td>24,800</td>
</tr>
</tbody>
</table>

2000 Expenditure (%)

- Management and administration: 12.6%
- Revalidation: 3.2%
- Education: 2.0%
- Standards: 2.0%
- PLAB test: 4.1%
- Registration: 21.6%
- Projects: 2.1%
- Fitness to practise: 52.4%

2001 Expenditure (%)

- Management and administration: 12.4%
- Revalidation: 2.2%
- Education: 1.3%
- Standards: 1.6%
- PLAB test: 4.1%
- Registration: 18.6%
- Projects: 0.1%
- Fitness to practise: 55.7%

The statement of income and expenditure shown above is an extract from the GMC’s audited accounts. For a proper understanding of the accounts the full accounts and their supporting notes should be read in conjunction with each other.
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 3493
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 3680
Email health@gmc-uk.org

Performance procedures
Telephone 020 7915 3667
Fax 020 7915 3642
Email performance@gmc-uk.org

Inquiries about standards and ethics
Telephone 020 7915 3588
Fax 020 7915 3599
Email standards@gmc-uk.org

Main switchboard and fax
Telephone 020 7580 7642
Fax 020 7915 3641
Email gmc@gmc-uk.org

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.