Changing times
Changing culture

A summary review of the work of the GMC since 1995

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GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors
As citizens we have clear expectations of our public services. In the health service we demand good standards of access, treatment and care. We are not prepared to tolerate unacceptable variations in the standards of provision and performance, nor put up with long queues and waiting times for access to the essential services. Nor are we prepared to accept attitudes to service which seem to favour doctors more than patients.

Cultural and structural change
Closing the gap between public expectations and the reality of delivery requires significant cultural and structural change in the services themselves. Equally it demands a new order of investment by government in the health professionals, systems and the general infrastructure needed to ensure good quality care for all citizens.

These challenges are reflected in microcosm in the process of medical regulation. Until recently, professional regulation was a backwater for the medical profession and government in the totality of healthcare. Many recent serious cases brought before the GMC’s conduct and performance committees represented problems that had endured for some time. While there had usually been local suspicions, the fact that no preventative action was taken demonstrates that there has been too much tolerance of poor practice. The system under which these cases arose, operated by the medical profession, by successive governments and the NHS, was deemed acceptable in its time. Now, that system of medical regulation has been thrust into the limelight. In the GMC we accept full responsibility for our part of the system and for making the changes needed to make that part safe and effective.

A new approach
This review covers the five eventful years between 1995 and 1999. These years mark the end of the traditional approach to medical regulation – virtually unchanged since 1858 – and the welcoming of a new approach. The new approach is characterised by the emergence of an explicit culture of professionalism in medicine, which brings the public and the medical profession closer together on the qualities both expect in our doctors. Medicine is inherently a judgement-based profession, but by putting patient safety first, our new professional culture seeks to minimise the risks of clinical error. It does this by replacing blame, secrecy and misplaced professional solidarity with the attitudes, language and habits of quality improvement. Openness is the key.

The General Medical Council has been criticised for the slowness of its fitness to practise procedures and because of the public perception that in its judgement of some individual cases, it favours doctors rather than patients. It has needed to be stimulated and provoked – from within and without – and to become more public service minded, to modernise its structures and governance, to be more proactive, responsive, efficient, open and accountable. Managing this kind of cultural change within an organisation is challenging.

We are witnessing the fashioning of a new relationship between the medical profession and the public, and an approach to medical regulation to which all major stakeholders must contribute.
“The years 1995–1999 mark the end of the traditional approach to medical regulation and the welcoming of a new approach.”
Chief Executive’s report  We know we will be judged on the quality of our services and how well we respond to fresh challenges.  Finlay Scott
In 1995, we started a programme to modernise procedures and to ensure ready access to good quality services. We began to identify where new approaches, supported by better technology, would best sit beside proven processes. Everyone who deals with the GMC is entitled to good standards of service. Our aim was to turn that expectation into a reality and to place our services at the top of any league table of regulatory bodies.

The results to date include some significant achievements.

Achievements
There have been major improvements in our registration services. They include eliminating long-standing delays in the ‘Professional Linguistic Assessment Board’ (PLAB) test; making Part 1 of the PLAB test available overseas; substantially reducing the time taken to grant all forms of registration; ensuring a better understood, more consistent, basis for the transition from limited to full registration; and upgrading our registration inquiry service to run 24-hours per day, seven days each week.

There have also been substantial changes in the fitness to practise procedures, which handle complaints against doctors. They include introducing the performance procedures ahead of schedule; overhauling the screening of complaints against doctors; cutting delays within the health procedures; and generally making our services more relevant, accessible and responsive.

Above all, we have worked to make a reality of the Council’s insistence that our processes and procedures should be objective, fair, transparent and free from discrimination. However, there is no room for complacency.

Service standards
We have explicit service standards in some areas but extending them throughout the organisation has proved difficult. This has been particularly true where a combination of growing workloads and changes in policy has left us struggling to cope with the volume of work. As a result, not all our services are up to scratch; and there is too much inconsistency in our performance.

That inconsistency detracts from the good work we do; and saps confidence in the organisation as a whole. For example, a three-fold rise in complaints against doctors, coupled with a more rigorous approach to those complaints, has led to unacceptable delays. We need to eliminate those delays; and we have the necessary actions in hand.

Feedback
Those actions will be part of a determined drive to define clear standards for all our services, supported by consistent evidence of delivery. The views and experiences of those who use our services are vital. Many doctors, particularly from overseas, have welcomed the improvements we have made. We will extend the opportunity for feedback, through periodic surveys and better management information, to ensure we continue to adapt to meet the needs of those who use and depend on our services.

Accountability
Value for money has been and will continue to be important. As a public service, funded by the profession, the GMC is accountable for the proper use of resources. Value for money is fully consistent with fitness for purpose and the emphasis we place on the quality of our services.

The Council and my colleagues want a GMC that is fit for purpose in today’s conditions, delivering professionally led regulation in partnership with the public. We know we will be judged on the quality of our services and how well we respond to fresh challenges. The Council is committed to a continuing modernisation programme that will ensure we meet the requirements of a modern regulatory organisation and reflect best practise.

This five-year review is largely about what has been achieved. As we look ahead, our aim is to deliver what the public and doctors expect from a modern regulatory organisation.

“The Council wants a GMC that is fit for purpose in today’s conditions, delivering professionally led regulation in partnership with the public.”
A new direction
People want doctors who are up-to-date and skillful, who will treat them with kindness and consideration, and respect their views. They want doctors they can trust.

**The role of the GMC**

The GMC licenses doctors to practise in the UK under the provisions of the Medical Act 1983. Its purpose is to make sure that the public is served by doctors who have the qualities it expects, and to protect the public from doctors whose conduct, professional performance or health places patients at risk. It has four main functions:

- to set general standards of professional competence and conduct;
- to keep up-to-date registers of doctors who are capable of practising in accordance with these standards;
- to supervise the basic training of doctors in our medical schools and to co-ordinate all stages of medical education; and
- to deal firmly and fairly with doctors whose fitness to practise is in doubt.

In 1995 the GMC set professionally led medical regulation in a new direction. For the first time it published a comprehensive statement – or code – setting out the principles of *Good Medical Practice*, at the core of which it listed the *Duties of a Doctor*. It linked these principles and duties, which command widespread public support, explicitly to a doctor’s registration to form the basis of the professional contract between doctors and their patients. Doctors accepting GMC Registration are therefore making a commitment – a promise – to their patients and to their profession to practise accordingly.

*Good Medical Practice* now sets the framework of professional standards within which doctors must practise in this country. Doctors are being educated and trained according to these standards. The next step is to ask doctors to demonstrate regularly – from their graduation throughout their active professional lifetime – that they are practising in accordance with these standards through regular assessments of their performance. It will be their opportunity to show that they are holding to their commitment – their promise.

The revalidation of doctors’ registration will be based on the results of these assessments. So, for the public, registration will become an up-to-date statement of a doctor’s fitness to practise, not an historical record of qualifications acquired at the start of a doctor’s career. If there are serious doubts about a doctor’s practice he or she will be judged by the GMC and decisions made about the doctor’s registration against the template of *Good Medical Practice*.

There are many challenges facing modern medicine and the culture of medicine has to change to meet those new demands. The GMC must play a leadership role, replacing secrecy with openness about performance and results.”

Helena Kennedy QC, The British Council

This new direction is the most radical and fundamental change to medical regulation since 1858. It flows from the need for a new culture of professionalism in medicine, more in tune with public expectations. The fostering of this culture is at the heart of medical regulation operated by the GMC.
Changing times
During the past 50 years medical practice has altered dramatically. Science and technology have given doctors powerful tools that have advanced medicine’s capacity to extend and improve the quality of life. But the pace of change in bioscience and in medical practice has, in some ways, outstripped the development of medical professionalism. These advances have tended to push doctors towards a scientific model of medicine in which the need for good communication skills and human understanding has sometimes been overlooked.

By the early 1990s it was clear that public attitudes and expectations were changing fast. Too many doctors were seen by the public as limited in their willingness and ability to communicate effectively; to act promptly to protect patients from poor practice; to be open about risks and unjustified variations in performance; and to admit to the errors that are an everyday occurrence in judgement-based clinical decision-making. Consequently there was increasing pressure on the profession to show that doctors were up-to-date, competent, would have respect for their patients’ views and decisions, and would communicate with them effectively. Patients are increasingly expected to take decisions about their care, seeing doctors as their expert advisers rather than controllers of their destinies.

This clash of cultures crystallised during the course of the GMC hearing in 1998 concerning the tragedy in paediatric cardiac surgery at the Bristol Royal Infirmary. This and several other significant cases at about the same time provided the emotional fuel for change. As a result the government and the NHS introduced new arrangements for strengthening institutional responsibility and accountability for standards of clinical care. Specific proposals for modernising medical regulation, particularly in the arrangements for dealing with poorly performing doctors, have been introduced in the consultation paper Supporting Doctors; Protecting Patients.

At the same time the GMC, with the active support and involvement of the Royal Colleges and university medical schools, accelerated the programme of modernisation it had started earlier. In particular it introduced its proposal for the revalidation of registration. It was building on the foundations which were laid at the beginning of the 1990s with the early work on Good Medical Practice, the introduction of a new curriculum in the medical schools – Tomorrow’s Doctors – and the preparatory work leading to the Medical (Professional Performance) Act of 1995.

Changing the culture and practice of the GMC
Behind the changes of the past five years lie assumptions, which have become clearer and firmer as we made progress with our reforms:

- Patients and doctors must be clear about – and share – explicit principles of good medical practice.
- Those explicit principles should be the foundation of a doctor’s training and practice – from the first days as a medical student through to the end of the doctor’s practising career.
- Doctors whose practice falls short of those principles are accountable to the GMC and may lose their registration.
- Delivering this reform of regulation requires clear guidance and effective implementation.
“The key challenge for the GMC in the future will be to continue to open its processes, and convince the public that it is as committed to protecting patients as it is to guiding doctors”

Donna Covey, Association of Community Health Council for England and Wales

“...there appears to be a genuine attempt, at least at the top, to make the words in its strapline ‘protecting patients’ a reality. That is very different from the past when the GMC was seen, certainly insofar as patients were concerned, to be simply interested in protecting doctors.”

Arnold Simanowitz, Action for the Victims of Medical Accidents
Raising the standard
Achievements secured between 1995–1999

Standards
• Professional standards bringing the public and the medical profession together on the essential attributes of a doctor – Good Medical Practice.
• Re-ordering of the functions and focus of the GMC, so that we concern ourselves directly with the conduct and performance of all doctors, not just those who err.
• Development of the attributes of clinical teams, characterising effective clinical governance at a basic operational level – Maintaining Good Medical Practice.
• Specific guidance on consent – Seeking Patient’s Consent: the ethical considerations; on Serious Communicable Diseases; and on The Doctor as Manager.

Education
• Implementation of a new curriculum in all medical schools in the UK, laying the foundation for graduating doctors with the desired attributes – Tomorrow’s Doctors.
• Reform of the pre-registration year and the senior house officer (SHO) period, consolidating under proper supervision the clinical knowledge and skill of new doctors – The New Doctor and The Early Years.
• Professionalisation of medical teaching – The Doctor as Teacher.

Registration
• Decision to introduce the regular revalidation of doctors’ registration; the development of method; and extensive consultation about how to take this forward.
• Strengthening of arrangements for assessing suitability of doctors from overseas for practice in this country. Introducing more robust arrangements for monitoring the performance of doctors practising in this country under Royal College sponsorship schemes.
• The creation of an automated registration enquiry service, giving the public and employers 24-hour access.

Fitness to practise
• Procedures for implementing the Medical (Professional Performance) Act 1995; the development of robust performance assessment methods designed to be used in the setting of a doctor’s practice; the training of skilled medical and lay assessors; and early experience of operation.
• Progress in the huge task of modernising the management of the existing fitness to practise procedures; and how these could look in a much simpler legislative framework.
• Decision to make restoration to the register following erasure exceptional.
• Decision to seek new statutory powers on interim suspension and on restorations; and on the use of people from outside the Council for fitness to practise work, so that cases can be heard promptly, with more lay input.

Governance
• Signing up to the Better Regulation Task Force principles of sound, professionally-led regulation.
• Commitment to the Commission for Racial Equality programme against racial discrimination.

Communication
• Creating a new directorate, to give this neglected aspect of the GMC’s business the priority needed to enable the GMC to communicate effectively.

International relations
• Taking an active part in seeking better co-operation and co-ordination between the medical licensing bodies in other countries.

“The GMC must work with doctors to bring about a change in culture within the profession. But the real challenge will be to ensure that the patient is at the heart of everything it does.”

Sheila McKechnie, Consumers Association
Learning from the past and looking to the future

Some of the major changes we have made to the work of the Council

Changing orientation – putting patients first
Throughout the period the GMC has moved steadily from a primarily medical to a primarily patient focus. Examples of this change include the decision in 1996, to double the number of lay members; the inclusion of lay assessors in the performance procedures; the establishment of a standing group of patients’ organisations to put the wider public view; and the emphasis in Good Medical Practice on patient requirements and expectations.

The adoption of explicit standards
These form the basis for all advice to the profession now given by the GMC. As important, explicit operational standards of access and the delivery of services by the GMC itself are now being developed, and will be in use in 2000.

A service orientation
The GMC has long had a reputation for being excessively bureaucratic, user-unfriendly and slow. There is now an institutional determination to change, reinforced by many members of staff who actively promote this. Examples of change include the new, engaging and helpful approach to complainants and doctors adopted by the fitness to practise directorate in 1999, and the strong client service orientation adopted successfully by our registration directorate.

From reactive to proactive
The GMC’s traditional stance has been reactive, reflecting an unspoken mood in the medical profession that it should interpret its functions narrowly, and not be intrusive or assertive. The public, on the other hand, has been expecting the complete opposite, a regulating body that would be vigorously proactive on its behalf.
“The challenge is to harness the many initiatives now underway into a coherent and effective organisation which secures good doctors, a responsive and respected process when things go wrong and a perception by both the public and the profession that we serve their interests fairly.”

Angela Macpherson, GMC lay member

By far the best example of the change in stance is the new-found determination to see that professional and educational standards are actually implemented, that the GMC means what it says. Ensuring the implementation of Good Medical Practice, Tomorrow’s Doctors and The New Doctor is the best expression of this.

Audit, openness and accountability
Like the wider medical profession and the NHS, the GMC has had no history or culture of systematically auditing its own performance, of opening itself up to outside scrutiny, or of offering meaningful analyses of its activities. Now, just as it asks these of doctors, it is seeking to apply the same disciplines to itself.

We have made a start, but progress has not been as rapid as we would like. Examples of internal audit are the recent customer satisfaction survey of doctors seeking registration and audits of the results of screening. Significant independent external audits have been carried out on the question of racial discrimination in the screening procedures and the performance of the health procedures, the results of which have been published and acted upon. And we have commissioned independent surveys of public and professional opinion on the Duties of a Doctor, which have been published recently.

Training
We have established a new training centre and a more systematic approach to the continuing development of staff. Recent initiatives include the very successful training of performance assessors, and the introduction of training for members serving on fitness to practise panels.

Collaborative working
Another manifestation of the change in GMC culture is demonstrated by a new commitment to collaborative working, founded on the belief that the GMC cannot and should not see its work in isolation or try to do everything itself.

Examples include the inclusive approach to policy development and to the machinery for implementing revalidation. Further innovations include the new Joint Standing Committee with the Royal Colleges and fresh ways of dealing with other stakeholders in the health sector. We have developed new relationships with employers of doctors inside and outside the NHS and with the Scottish Parliament and the Welsh Assembly; and we have established close relationships with the Commission for Health Improvement (covering England and Wales), and the Clinical Standards Board in Scotland.
Our objectives for early implementation

- A major overhaul of the GMC’s structure, constitution and governance.
- A reconstruction of the legislative framework for managing complaints about doctors.
- The implementation of revalidation.
- New editions of *Good Medical Practice* and *Tomorrow’s Doctors*.
- Publishing details of our performance against explicit service standards.
- Development of methods for assessing doctors’ performance and for studying the characteristics of dysfunctional doctors.
“As one of the new lay members of the Council, I was surprised by the antiquated procedures of the GMC. But I am heartened that change has begun and hope that the medical profession as a whole endorses this process.”

Roland Doven, GMC lay member
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.