Theatre guide

Actors from the National Theatre help the GMC to engage with doctors and patients on issues of consent p3 and p15

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COMPETITION: win an iPod nano p3
The British Standards Institute has presented the ISO 27001 information security standard to the GMC – an assurance to doctors and the general public that the organisation is using best practice in handling information safely and securely. The nature of the GMC’s work means that we hold sensitive information about doctors and others, and have a duty to ensure that we handle all such information appropriately to minimise any risk of a security breach. Since 2003, the GMC has been working to upgrade systems and procedures to be audited against a benchmark that is respected worldwide.

BSI managing director Neil Hannah commented: ‘This standard is considered to be the most comprehensive set of security best practice controls available and encompasses everything from people to physical environment to IT systems.’ Achieving the standard is not a one-off event but involves ongoing assessment and review to ensure the effectiveness of procedures. Other organisations to be awarded ISO 27001 include the Food Standards Agency, BUPA and PriceWaterhouseCoopers.

Consensual disposal

The GMC has been running consultation workshops in all four countries of the UK on extending the resolution of fitness to practise cases by consensual disposal – a method currently only used for doctors in ill health or whose performance is deficient. Under the proposals, it would be available in all cases, except where there is a realistic chance of the doctor being erased if referred to a Fitness To Practise panel.

The changes would mean fewer hearings, since consensual disposal allows the GMC to agree binding undertakings with a doctor. It is an effective, timely and proportionate way of resolving certain types of concern.

The workshops have provided an opportunity for organisations to raise concerns or make suggestions. Representatives from a range of groups, including the medical defence organisations, Action against Medical Accidents and the King’s Fund, contributed as part of the wider consultation.
National acts on issues of consent

As part of our consultation on the new consent guidance, the GMC held five workshops in early summer using actors from the National Theatre’s Theatreworks programme. Working with the Alzheimer’s Society, Scottish Dementia Working Group, Age Concern in Northern Ireland and Dementia Care Partnership, the sessions were held in Cardiff, London, Belfast, Glasgow and Newcastle. At each venue an invited audience of patients, carers and doctors commented on, and even participated in, an acted scenario involving a patient whose capacity to make decisions for himself was affected by early-stage dementia. The aim of the workshops was to provide an opportunity for doctors, patients and carers to discuss their views and concerns about the issues which arose.

In this editorial I want to concentrate on how we can engage more effectively with doctors. I do not mean simply communication: we must also demonstrate that we are actively seeking doctors’ views and listening to them, and doing so not just when we are finalising policy, but from the earlier stage of developing new ideas.

Our starting point is that we need to engage with the profession as a whole. This is not a question of how many doctors there are on the Council, or about the meetings that we have with representative bodies, or about the formal consultation documents that we put out, important though all those matters are. It is about recognising that the medical profession is increasingly diverse and heterogeneous, and that we are the national regulator for doctors in all four UK countries.

If that is the right place to start – and the Council is convinced that it is – some consequences flow from it. The sheer size of the medical population is such that there is unlikely to be one solution; rather we need to develop a variety of approaches. Given the considerable demands on doctors’ time, we also need to make best use of technology to make it straightforward and quick for doctors to let us know what they think about the challenges facing us.

How might this work? Some regulators have developed panels of consumers and practitioners to provide advice to the regulatory body and enable the regulator to ‘take soundings’. We are going to examine how a panel of doctors on those lines might work. We could, for example, develop a virtual panel of several hundred registered doctors, representative of the profession, with whom we could engage through e-questionnaires or polls. We could draw on the panel for focus groups to explore particular issues in depth.

We could perhaps bring the virtual panel together for a conference every year to discuss the GMC’s plans for the coming year.

Those are some of our ideas. Why don’t you tell us some of yours? Please email gmctoday@gmc-uk.org

WIN an iPod nano!

In the video of his seminar speech (on the GMC website) Sir Graeme Catto says there are ‘five or six’ principles that are important to the GMC Council. Name two of them.

Email your answer with ‘GMCToday competition’ as your subject line to gmctoday@gmc-uk.org or send a postcard to The Editor, GMCToday, 350 Euston Road, London NW1 3JN

Closing date for entries is 20 August. The first correct answer picked at random after this date wins. Editor’s decision is final.
Useful exchange of views at Royal Society seminar

Over 150 delegates from across the UK met at a GMC-organised seminar at the Royal Society in London to consider how best to take forward the principles for reform of healthcare professional regulation, as set out in the recent White Paper: Trust, Assurance and Safety.

The event provided an opportunity for the GMC to hear from a cross-section of delegates with an interest in medical regulation. These included patient representatives, individual doctors, employers and providers of healthcare, professional representative groups, Royal Colleges and medical schools.

In his opening remarks, GMC president Sir Graeme Catto set out the principles which underpin the Council’s approach to reform. These include the commitment that regulation should put patient safety at its heart, be independent of government and dominance of any one single group, strengthen connections between the workplace and national regulation as well as command the confidence and support of those who receive and deliver healthcare across the UK.

Speaking on behalf of the government, the deputy chief medical officer for England, Professor Martin Marshall, emphasised that the Department of Health wanted to ensure the views of doctors are taken into account when it comes to developing legislation. He also argued that revalidation must be more than a ‘tickbox’ exercise. ‘Revalidation needs to be robust but must not become a bureaucratic industry,’ he added. ‘The balance between accountability and letting people get on with their job is a major challenge we need to address.’

Commenting on the White Paper, GMC chief executive Finlay Scott said: ‘This is a unique opportunity to build a modern framework for medical regulation, with patient safety at its heart.’

To provide a flavour of the event, the GMC has made some of the seminar presentations available to view, through web streaming, on our website www.gmc-uk.org

What did you make of the presentations? Email your thoughts to gmctoday@gmc-uk.org
• Competition, p3

Future reforms for GMC constitution

One of the White Paper reforms requiring early legislation will be the governance and constitution of the GMC. A new, all-appointed Council (50 per cent medical and 50 per cent lay) will be in place no later than December 2008. At the time of going to press, we understand that the government plans to publish draft legislation in the summer or autumn this year. We anticipate that this will cover the key principles around the governance of the GMC, with the detail (such as the size of the Council) to be included in a separate Constitution Order to be published next year. We will provide an update on these plans once the final detail is confirmed.
A new partnership of trust

Electronic data is now theoretically available anywhere in the world at any time and at any place and - unlike doctors’ handwriting – it can be read or used by clinicians, patients and computers alike.

But what should patients confide to the doctor and with whom should the doctor share this data? Hospital doctors, GPs and nurses treat patients using separate records that are unable to link with one another – so does this mean confidentiality actually reduces the safety and effectiveness of care?

A change in doctors’ attitudes about sharing data is necessary – records should follow the patient around, with the patient controlling the access.

Of course, there are very real issues here: for example, vulnerable people, such as the elderly or those with mental disabilities, will find it difficult to manage complicated security technologies – yet, as they are least able to represent themselves and their conditions, they may stand to benefit most from the sharing of electronic records.

So how do we build and maintain trust in electronic records?

Among other things, doctors and patients need to:

- be able to identify who stores, uses and manages data
- know who has seen the various parts of the records
- understand that data cannot be deleted from the record but can be hidden, quarantined or annotated
- know that some data cannot be seen at all without the patient’s consent
- know who can use the care record in the patient’s absence
- understand the clinician’s responsibility to disclose information when the public is at risk

Honesty, openness and transparency are paramount: doctors are contractually obliged to make a record of their consultations and patients should be able to see this information as soon as it has been recorded. Doctors will be able to record some data so that only they can see it. Patients may request that socially sensitive information is never shared without that third party’s consent. Existing legal safeguards will protect this sensitive information.

Patients must be able to access their complete record in order to reduce the fear that ill-health can cause and to allow them to make informed decisions about their care. Patients, IT specialists, clinicians, administrators and doctors need to come together to create, publish and update a new, liberal and emerging regulatory framework for the data that is to be disclosed, recorded, shared and corrected in electronic records.

About the authors

Dr Richard Fitton and Dr Amir Hannan are both GPs and members of the Record Access Collaborative. Fred Webber and Yvonne Bennett are patients who have been consulted in the creation of patient-centred medical services in the Tameside and Glossop PCT.

Case study:

Painful feet presented serious problem

On a typical busy day a young African male came to A&E, complaining about his very painful feet. He was unable to weight bear and his feet were very tender. X-ray and routine blood tests were done. There wasn’t any history of trauma and the X-ray turned out to be normal.

A provisional diagnosis of plantar fasciitis was made. On blood tests we found his Hb was very low and there was some sickling of his RBCs. Surgical causes were ruled out. Thinking of it as a sickle cell crisis, the patient was transferred to the medical assessment unit.

The patient was further diagnosed while having a blood transfusion. He had cervial and axillary lymphadenopathy and hepatosplenomegaly. The CXR showed miliary shadowing. Now the entire diagnosis was questioned and, after counselling, an HIV test was carried out which turned out to be positive.

The patient was later started on antiretroviral and antituberculos therapy.

There were some complaints of low grade fever, rigors and chills for weeks but he came into A&E because of his very painful feet. This was later explained as HIV Neuropathy and the low Hb was explained by alpha thalassemia trait.

I just wonder how many doctors have come across a presentation that has ended up with such an unexpected diagnosis.

Dr Farooq Usman, SHO Surgery, Ysbyty Gwynedd, Bangor
When it comes to the link between obesity and cancer risk, doctors are in the front line of the fight. The World Cancer Research Fund (WCRF) has already warned of the time bomb waiting to explode in the NHS.

But despite this, there is still a long way to go when it comes to increasing public awareness. People are generally aware that being obese has a direct effect on their chances of having a heart attack, but is there the same awareness about cancer? I don’t think so.

We do not fully understand the reasons for the close link with obesity, but there is substantial emerging evidence of the role of adipose tissue, particularly visceral adipose tissue, as a metabolically active endocrine organ. This leads to the release of insulin-like growth factors that are linked to increased cancer risk.

But whatever the mechanism, it is crystal clear that the link exists, and that the number of obese people in the UK is going up. The prevalence of obesity has trebled since the 1980s, and well over half of all adults are either overweight or obese, according to the Department of Health.

And an increasing number of obese people will lead to more cancer cases. Any future increase in cancer patients will add to the already high cost of treatment in a climate where the availability of drugs is a political issue. And this is not to mention the human suffering that comes with cancer.

Prevention being better than cure, people need to be informed that eating healthily and being physically active can make a big difference to their cancer risk. Many people seem to think, incorrectly, that developing cancer is largely a question of their genetic inheritance or luck – WCRF puts the proportion of cancers that could be prevented by a healthy diet, physical activity, and maintaining a healthy body weight at between 30 and 40 per cent.

While it is often difficult for doctors to tackle weight issues with defensive patients, simple messages can be effective in contributing to behaviour change. It is important that people are empowered by having practical advice on how to prevent cancer. While it is often difficult for doctors to tackle weight issues with defensive patients, simple messages can be effective in contributing to behaviour change. Linking weight to an existing medical condition is often an opportunity to raise the issue of weight management with patients, for example asking whether they are aware that losing weight could help reduce their blood pressure. Talking to patients about the link between lifestyle and cancer prevention can make a big difference, and the same lifestyle choices that help prevent cancer also help to prevent other chronic diseases such as heart disease and diabetes.

In November, WCRF will be releasing the most comprehensive report ever published about the link between lifestyle and cancer. It has been put together by 21 leading international experts in fields such as nutrition, cancer biology and public health, and they will make a series of recommendations that people can incorporate into their daily lives. Please watch out for the report, since it will be a useful tool in advising patients on what they should be doing to reduce their own cancer risk.

For details about education resources, visit www.wcrf-uk.org. You can also sign up for WCRF’s Informed newsletter, aimed at health professionals, by emailing informed@wcrf.org.
At this time of year 5,500 newly-graduated doctors are welcomed to the GMC register. As well as getting a letter from the Registrar explaining what the GMC does, they receive a variety of booklets such as Good Medical Practice describing what is expected of them.

In these, each doctor is reminded of his or her continued responsibility for maintaining registration effectively – something that is essential to allow the GMC to keep the register up to date. Paying the annual fee, letting us know if they change address and informing us of anything else impacting on their fitness to practise are all key requirements.

So why is effective registration so important?

→ It is a legal requirement that the GMC register includes an address where a doctor can be contacted

→ Every registered doctor is responsible for providing this

→ The address is not in the public domain - only employers and other authorised recipients have access to it

We are working all the time to improve the ways we explain to new registrants how they can help us to help them maintain their registration effectively.

What happens if doctors don’t maintain their address?

→ They may find themselves removed from the register – and, of course, doctors not on the register cannot work as medical practitioners in the UK

→ Each year nearly 2,000 doctors persistently fail to respond to correspondence sent to their registered address

→ The GMC’s statutory responsibility requires us to commence a process to update the address

As well as the usual means of maintaining personal details - by email, telephone and post – doctors can now do this through MyGMC, our online facility for managing registration (see below). The vast majority of doctors who run into problems have simply failed to tell us that they have moved – and this can be easily rectified. But the key thing to bear in mind is that maintaining effective registration saves doctors a great deal of unnecessary inconvenience.

Contact us

Got a question about maintaining effective registration? Want to give us some feedback on the current process?

Tel: 0161 923 6602 or, if you are calling from outside the UK, 0044 161 923 6602; email: registrationhelp@gmc-uk.org or write to: Registration, GMC, St James’s Buildings, 79 Oxford Street, Manchester M1 6FQ

Euro MPs back GMC call for better patient safety rules in Europe

The Alliance of UK Health Regulators on Europe (AURE) - a partnership of all ten UK professional health and social care regulators – is calling on the European Commission to propose a legal duty on health regulators to exchange registration and fitness to practise information.

This call, backed by the GMC, would ensure that incompetent practitioners can’t country-hop around the EU to avoid detection and put patients at risk. AURE also wants to be assured that practitioners wishing to move between countries are up to date. At present, under European law, the ability of doctors to take up practice in another member state is linked mainly to possession of the relevant primary medical qualifications – there is no requirement for them to demonstrate that they have remained up to date. With the introduction of revalidation, it is appropriate that practitioners should be expected to provide such an assurance before they are able to take up practice.

The GMC is lobbying Brussels ahead of changes to European law which could see the current competence, as well as qualifications, of medical practitioners taken into account when applying for jobs

Existing free movement rules for health professionals fall short of assuring patient safety

AURE’s lobbying strategy has so far proved highly successful. When MEPs voted in the European Parliament on a recent report on European health services, they followed the UK regulators’ lead by calling for a legal duty on regulators to exchange information. MEPs also recognised AURE’s concern that existing free movement rules for health professionals fall short of assuring patient safety.

New laws are likely to impact on how the GMC regulates European Economic Area-trained doctors in the long term, therefore any new proposals – and subsequent legislation – must be consistent with modern and effective medical regulation and the maintenance of patient safety. The GMC will be working closely with AURE to influence EU proposals. The European Commission is due to issue draft proposals on cross-border healthcare in late 2007.
The cornerstone of the GMC's new registration framework, which will be introduced on 19 October, is the abolition of limited registration. This category currently applies only to international medical graduates (IMGs) – but in future the new framework of provisional and full registration will apply equally to all doctors, no matter where they qualify.

Limited registration was, to use a current phrase, 'fit for purpose' when introduced in 1979. But fundamental changes in healthcare regulation since then – the development of clinical governance within the NHS, the quality assurance role of bodies such as the Healthcare Commission and NHS Quality Improvement Scotland, plus the future introduction of revalidation for doctors – mean limited registration no longer adds value.

Abolishing it is part of the GMC’s continuing programme of reform and will assure both patient safety and equality of treatment for doctors. It will also mean greater clarity for anyone who needs to consult the register.

How will this affect doctors?

In future IMGs will be able to apply direct for provisional or full registration. They will still need to satisfy a number of criteria before this is granted, but will no longer need an offer of employment beforehand. Breaking the link between registration and employment means IMG recruitment should be more straightforward in future.

All doctors granted provisional registration will be restricted to working in Foundation Programme posts. Those granted full registration for the first time, and starting new jobs – UK graduates as well as IMGs – or returning to the register after a prolonged period out of UK practice, will be required to work initially within an approved practice setting (APS).

What are approved practice settings?

These are organisations which have effective clinical governance systems and so provide a suitable environment for newly registered doctors. The GMC has been working closely with the health departments and quality assurance bodies in the four UK countries to ensure that the APS criteria are robust and workable, and
fit with the mechanisms for assuring core standards which are already in place. Bodies which comply with the core standards used in the Healthcare Commission’s annual health check – or in comparable mechanisms in Wales, Scotland and Northern Ireland – should have no difficulty satisfying the GMC’s APS criteria.

You can find the criteria listed in full on our website, [www.gmc-uk.org](http://www.gmc-uk.org), where doctors will also be able to check organisations’ APS status. Foundation Year 2 posts are likely to qualify automatically as an APS environment. Doctors who want the requirement to work within an APS lifted will need to provide the GMC with confirmation that they have satisfactorily completed 12 months’ practice in such a setting. This can be done in two ways:

- the Foundation Achievement of Competency Document (FACD), if they are based in the Foundation Programme
- a report by their supervising consultant, if they are not in the programme

**Should IMGs apply for provisional or full registration?**

This will depend on the nature and extent of their postgraduate experience. If they have satisfactorily completed either Foundation Year 1 in the UK or a period of postgraduate clinical experience that provides an acceptable foundation for future practice as a fully-registered medical practitioner, they may apply for full registration. If they have not, they may apply for provisional registration.

Doctors who meet the criteria for full registration will not be eligible for provisional registration.

**Contacting doctors**

The GMC is writing to all doctors currently holding limited registration, or whose limited registration is currently suspended, or who have an outstanding application for limited registration, to explain the transitional arrangements in full and what they need to do next. If you fall into any of these categories, or know someone who does, please ensure we have up-to-date contact details.

The requirement to work in an APS will take immediate effect for IMGs on 19 October. Because of the start date of UK training posts, the changes will not take practical effect for UK graduates until January 2008.

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**LIMITED REGISTRATION: THE FACTS**

**How does limited registration work at present?**

IMGs have to work in supervised employment, restricting the type of job they can undertake. There’s a maximum time limit of five years, typically granted in short periods of six to 12 months. But the real constraint is that IMGs must have a job offer before they can be granted limited registration. Most are able to move to full registration a year or so later, subject to supportive reports from their supervising consultants. UK graduates who have successfully completed a period of provisional registration, meanwhile, move straight to unsupervised practice under full registration. The ‘two-tier’ system is seen as unfair to IMGs, makes efficient utilisation of the medical workforce more difficult and places a disproportionate regulatory burden on doctors, employers and regulator.

**Transitional arrangements for IMGs**

- Doctors holding limited registration on the day that it is abolished will automatically be granted full registration (unless they are restricted to working in a Foundation Year 1 or house officer post), on condition that they only work in an APS until they have fulfilled the criteria for that requirement to be lifted
- Doctors under limited registration who are restricted to working in a Foundation Year 1 or house officer post will automatically move to provisional registration
- Any fitness to practise conditions imposed on doctors’ limited registration will carry forward to their full or provisional registration
- Doctors who have an outstanding application for limited registration at the point it is abolished, or who have held limited registration in the past, will be treated as a first time applicant for full or provisional registration

**New criteria for registering IMGs**

IMGs applying for either provisional or full registration will be required to satisfy the GMC that:

- They hold an acceptable primary medical qualification
- They have the requisite knowledge and skills for registration
- Their fitness to practise is not impaired
- They have the necessary knowledge of English

Doctors may demonstrate their medical knowledge and skills in one of the following ways:

- A pass in the Professional and Linguistic Assessment Board (PLAB) test
- Sponsorship by a medical Royal College or other sponsoring body for further postgraduate training
- An acceptable postgraduate qualification
- Eligibility for entry in the Specialist or GP Register

Doctors applying for full registration must also submit evidence that they have satisfactorily completed either Foundation Year 1 in the UK or a period of postgraduate clinical experience that provides an acceptable foundation for future practice as a fully registered medical practitioner.

Keep checking our website, [www.gmc-uk.org](http://www.gmc-uk.org) for more information.
In June, GMC president Sir Graeme Catto officially opened the hi-tech Clinical Skills Education Centre (CSEC) in the Medical Biology Centre at Queen’s University Belfast.

The centre uses equipment including mannequins, online resources, video feedback and advanced simulators in programmes which aim to provide reliable, valid and practical procedures to assess students’ competence. ‘Simulated patients’ are used to encourage them to think about how patients feel. The centre’s ethos highlights the importance of allowing students to practise and develop clinical and communication skills from the outset of their training as a means to eventually providing patient-centred care.

Speaking at the opening, Sir Graeme said: ‘This state-of-the-art medical teaching facility will undoubtedly enable Queen’s University Belfast to address the principles contained in GMC’s Tomorrow’s Doctors and will help to deliver the highest quality education and training for doctors and health care professionals of the future.’

The election of a new British Medical Association chairman – Hamish Meldrum – and the MTAS crisis were among the main topics of debate during the BMA’s Annual Representative Meeting in Torquay at the end of June. But the issue of the future of medical regulation also drew a sizeable audience to the GMC’s breakfast meeting at the event. GMC Council Members took the opportunity to listen and learn as well as respond to points raised by doctors during the question and answer session.

In a session chaired by Dr Edwin Borman, the panel took questions on a variety of issues. These included: the proposed change in the standard of proof, discussions about student fitness to practise and a student register, management of the online List of Registered Medical Practitioners as well as proposed governance changes to the GMC. At the heart of the responses given by the GMC Council Members was a recognition that the GMC must continue to find new and innovative ways to ensure it strengthens its engagement with the medical profession on all these issues and more.

GMC Scotland attracts positive feedback at Glasgow ‘Gathering’

Delegates from around the world spent time at the GMC Scotland stand at this year’s third sector event, called ‘The Gathering’ (see above), in Glasgow. Hosted by the Scottish Council for Voluntary Organisations, it brought together 5,000 voluntary sector staff, volunteers and community activists and 140 organisations. There was enormous interest from visitors in the issues addressed by the GMC’s recently-launched consent consultation.

The consultation was also a topic of discussion at GMC Scotland’s stand during the NHS Scotland Delivering Healthcare for the 21st Century conference in June. This was attended by a range of agencies and over 900 participants from across the NHS. New cabinet secretary for health and wellbeing, Nicola Sturgeon, also spoke at the event. Jane Todd, GMC head of Scottish Affairs, said: ‘These two conferences were positioned for very different audiences but the issues the delegates wanted to discuss with the GMC were very similar: standards and ethics, workforce development and building good relationships. Feedback was extremely positive.’
**Quartet of schools make the grade**

Following a rigorous assessment by the GMC education quality team, a quartet of new medical degrees has been approved.

Universities covering four medical schools in the UK will, for the first time, be able to award their own primary medical qualifications after completing the GMC’s quality assurance process for basic medical education (QABME).

They join established names such as Newcastle University, the University of Glasgow and Queen’s University Belfast.

Two of the medical schools are new: Peninsula, covered by the universities at Exeter and Plymouth, and the school at the University of East Anglia. Warwick and Cardiff universities can now begin issuing medical degrees in their own name. Up to now Warwick has issued medical degrees jointly with Leicester University, and students from Cardiff medical school have received University of Wales degrees.

Professor Yvonne Carter, dean of Warwick Medical School, expressed her delight at passing the GMC quality assurance process. ‘All our staff and students have worked extremely hard to reach this milestone and we are all looking forward to continuing success in the future,’ she said.

Schools devise their own curriculum to enable students to meet GMC standards, and they are regularly visited and assessed. Kirsty White, programme manager for the GMC’s quality assurance for basic medical education team, thanked the visiting teams for their work on the new schools. Professor Peter Rubin, chair of the GMC Education Committee, said the GMC worked closely with the new schools, engaging with them well before their first intake of students. ‘We put them through a rigorous, five-year assessment, taking account of developments in education theory and research, and professional practice,’ he explained. ‘For this work we bring in a diversity of educational, lay and medical experts, who can highlight good practice and also share innovations in medicine across a range of specialist fields. This will ensure medical students are going to be able to put into practice the principles laid out in Good Medical Practice.’

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**Medical Schools Council launches new strategy**

Formerly known as the Council of Heads of Medical Schools, the newly-named Medical Schools Council (MSC) will be focusing on the role of UK medical schools in relation to national health, wealth and knowledge creation through undergraduate and postgraduate education, bio-medical research and the profession of medicine itself. To achieve these aims the Council draws on expertise across medical schools – deans, researchers, teachers, admissions tutors, administrators, students – and the change of name reflects this broad contribution. The MSC is keen to engage with the public and with key stakeholders to implement this strategy and to debate the future role of the doctor.

The Council meets four times a year and divides its work into three main areas - one sub-group looks into education and admissions issues, another into research and a third into clinical staffing and employment. The acting chair of council is Professor Tony Weetman of the University of Sheffield who took over when Professor Sir John Tooke stood down in May as Chair for the duration of his independent review of Modernising Medical Careers.

The MSC is pleased to have been able to work closely with the GMC in the development of the draft guidance, Medical Students: Professional Behaviour and Fitness to Practise, and welcomes the positive support and advice provided by staff throughout the GMC as it works to improve medical education across the UK for the benefit of patients.

Further information: www.medschools.ac.uk

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**Katie Petty-Saphon**

Executive director

Medical Schools Council

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The Medical Schools Council has worked closely with the GMC on the development of student Fitness to Practise guidelines as it seeks to improve medical education, says the MSC’s Katie Petty-Saphon.
Breaking the Code

The Prescription Medicines Code of Practice Authority polices the pharma industry’s behaviour – and its director Heather Simmonds urges doctors to get in touch if they have any concerns over approaches by drug companies

Heather Simmonds
Director, PMCPA

The promotion of medicines for prescribing to health professionals by pharmaceutical companies is strictly controlled by the Association of the British Pharmaceutical Industry’s (ABPI) Code of Practice. The Prescription Medicines Code of Practice Authority (PMCPA) administers this Code at arm’s length from the ABPI.

Companies ruled in breach of the Code are subject to a number of sanctions including public reprimands, advertising in the medical and pharma press and possible suspension or expulsion from membership of the ABPI.

Doctors have complained about the promotion of a medicine, the conduct of representatives, claims in advertisements and excessive hospitality

Complaints are often made by doctors. Recently, doctors have complained about the promotion of a medicine prior to the grant of its marketing authorisation, the conduct of representatives, information or claims in advertisements and excessive hospitality. Breaches of the Code were ruled in many of these cases. Full details are available at www.pmcpa.org.uk.

So what should you look out for? In addition to the stringent requirements for printed promotional material and verbal claims, the ABPI Code states that:

 Pharma companies can sponsor meetings, such as presentations, at GP practices. Sponsorship must be disclosed in all papers relating to the meeting. Payment for rental for rooms to be used for meetings cannot be made directly or indirectly to health professionals

 It must be the scientific or educational content that attracts delegates to attend a meeting. Hospitality can only be provided with such meetings and not to individuals who do not qualify as delegates in their own right. Meetings of a social or sporting nature must not be used

 Promotional aids must be relevant to the recipients’ profession. They must cost no more than £6 plus VAT

 Companies can provide medical and educational goods and services which will enhance or maintain patient care or benefit the NHS. But they must not be provided in such a way as to be an inducement to prescribe, supply, administer, recommend, buy or sell any medicine and must not bear a product name – but can bear a company name. The involvement of the pharma company must always be made clear

 Therapy review programmes, which aim to ensure an individual patient receives optimal treatment following a clinical assessment, are permitted

 Representatives must not use any inducement or subterfuge to gain an interview and no fee should be offered or paid for it

 Good Medical Practice prohibits doctors from asking for, or accepting, any inducement, gift or hospitality that affects, or could be seen to affect, their judgement. It also states that doctors must declare all conflicts of interest.

More information

For the ABPI Code of Practice and a guide to the Code for health professionals, go to www.pmcpa.org.uk or call 020 7747 8881.

Complaints about the promotion of medicines, or the provision of information about prescription-only medicines to the public, should be sent to: complaints@pmcpa.org.uk or to the Director of the PMCPA, 12 Whitehall, London SW1A 2DY

Nye Bevan, the NHS’s founder, used to say: ‘Why look in the crystal ball when you can read the book?’ Good point. So we can confidently say that the NHS matters a lot to Mr Brown.

The NHS represents an idealistic collective endeavour to Gordon Brown, a tangible proof that we are each other’s keeper

It saved one eye when he suffered a teenage rugby accident. It nursed his children in infancy, and through his daughter Jennifer’s premature death. It will nurse his second son Fraser through cystic fibrosis.

The NHS represents an idealistic collective endeavour to this Scots Calvinist, a tangible proof that we are each other’s keeper.

So much for the high-minded theory. How will Mr Brown do better than Tony Blair in making the service responsive to the health needs of the British people?

We know from the Wanless reports that he believes it should remain taxpayer-funded and that people should be more closely involved in managing their own health: it’s cheaper as well as better. Expect more public health initiatives.

Mr Brown is saying that decision-making should be devolved, not to an NHS management board (he’s off that idea) or to the medics, but to local communities, patients as well as managers. He now backs trust hospitals.

What about the private sector’s role? Mr Brown, a champion of PFI hospitals, seems less keen on consumer choice in health, believing that we lack the expertise and that most hospitals are local monopolies.

Yet he has recently admitted that private providers have a role in diversity of supply and will demand value for money from the staff, from well-paid GPs and surgeons as well as cleaners. He feels that’s only right.
Revalidation: the debate continues

Sir Graeme Catto has appropriately rebutted the comment by Dr. Fielding, chairman of the BMA’s consultants committee, that the ‘proposed mechanism of revalidation would result in high cost and unnecessary pressure simply to identify a very small number of poorly performing doctors’. The White Paper deliberately anticipates this and sets out to discredit this misinterpretation.

It is worth noting that the White Paper does not recommend the imposition of sanctions on the ‘failing’ doctors but emphasises the need to understand the pressures and strains under which they operate, calling for understanding, compassion and support, and to give them a fair chance to return to practice. This represents a significant departure from the punitive approach often adopted. It is also encouraging to note that the Department hopes that the revalidation should be professionally led.

Dr Anton E Joseph, Consultant Radiologist, Mayday Hospital, Croydon

I read the summary of the government’s proposals ‘at a glance’ (GMCtoday, May). It will take more than a glance to interpret some of this. For example, what does this mean? ‘A revised system of NHS appraisal for doctors, incorporating standardised workplace 360 degree multi-source feedback’. And this from a government that criticises us for not speaking clearly to our patients! What it demonstrates is the distance the members of the committee that composed that phrase have drifted from communication with normal human beings.

Barry Fearn, FRCS, Hove

I am not opposed to revalidation. I write as one now ten years retired who has only remained on the active register because of the delays caused by rejection of the original plan. The original GMC proposals may not have been perfect but they were a good practical beginning and would have been improved over time. Quite apart from the delay I am very concerned about the way revalidation is going. What is good is the decision that the knowledge and experience enshrined in the Royal Colleges, now concentrated in the Academy of Medical Royal Colleges, is to be used. But why do we need to use the word relicensure? Is it not enough to call it revalidation?

Dr Stephanie Bown, LLM MBBS MRCP DRCOG FFFLM, Director of Education & Communications, Medical Protection Society

Painless Venflon

I wholeheartedly agree with Your Say about Painless Venflon (GMCtoday, Jan and March). I now recommend the following for training and practical application, after reassuring the patient, to minimise pain:

- Lignocaine 2% in insulin syringe 0.1 to 0.2 ml should be used before inserting Venflon size 14 to 19, and before arterial cannulation, blood donation or blood sampling

- For Venflon size 20 upwards perhaps the local anaesthetic or its sting might be avoided by ‘just a gentle cough please’ by the patient at the time of insertion

I hope this will improve our training and practice while reducing our patient’s pain.

Dr B B Bhala Consultant Anaesthetist, Wellingborough, Northants

Your Say

Your feedback and letters

Revalidation: the debate continues

Although the principle of revalidation might seem to be a solution to prevention of errors in practice, one is puzzled how it can ever be achieved effectively. To be efficient, it ought to be the equivalent of a regular ‘Final MB appraisal’ or examination for all and then a second higher qualification examination for all specialists. This is an obvious impossibility on a regular basis. The issue is further complicated by the increasingly narrow specialisation that is spreading throughout the practice of medicine. To quote an extreme example, who is to revalidate the practitioner who has developed a pioneering change and is now the world expert? Or is he or she now to be the one whose whole time is to be spent revalidating all others who practise in this field? Unless such real issues are resolved in a way to make them credible, revalidation will be merely a bureaucratic pipe dream.

George T Watts, ChM, FRCS, Moseley, Birmingham

Your feedback and letters

Email your letters, marked ‘For publication’ and no more than 150 words in length, to gmc.today@gmc-uk.org or post them to: GMCtoday, Editor, General Medical Council, 350 Euston Road, London NW1 3JN. Please include your full name, address and a contact phone number. Letters may be edited.

Voices in the crowd

I enjoyed the article on event medicine (‘More than one of the crowd’ GMCtoday, May). However, it was marred by the appalling phrase ‘for free’ in paragraph six. May we please have an editorial policy which requires a standard of English as good as the standard of medicine to which we aspire?

D N Kay

I would like to draw your attention to an error in ‘More than one of the crowd’. The error appears in the statement ‘It is worth contacting your professional body or insurer (such as the GMC or Medical Defence Union) to check that you are insured...’

It is misleading to refer to insurance, rather than indemnity. The Medical Act 1983 (Amendment) and Miscellaneous Order 2006 expressly refer to ‘adequate and appropriate indemnity’.

In addition, the GMC’s Good Medical Practice states: ‘You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer’s indemnity scheme, in your patients’ interests as well as your own’.

Dr Stephanie Bown, LLM MBBS MRCP DRCOG FFFLM, director of education & communications, Medical Protection Society
Beyond the jostling crowds of the Royal Academy’s Summer Exhibition, a selection of Benjamin Robert Haydon’s anatomical drawings can be found in a dimly lit upper gallery.

There was dissent between those who thought ‘the knife should go with the pencil’ and those who felt students’ efforts should concentrate on idealised figures of classical sculpture. Haydon’s passion for the former is evident in this exhibition of 18 of his early anatomical studies. From intricate sinewy drawings of the arm and shoulder to arresting images of leaden cadavers, partially dissected and slumped over the anatomy board, there is no sentimentality to be found here.

There is, however, a real sense of passion that emanates from the studies. I was intrigued by scribbles that the painter had added retrospectively to two of the drawings: ‘These legs were done previously to my having seen a dissection – so the tendon is not correctly marked...’ – testament to the unerring quest for accuracy in his art.

There is no question that these paintings are technically masterful works. If you prefer anatomy to abstraction, then this may be for you. And if not for the Haydon then pay a visit for the Summer Exhibition, the largest open contemporary art exhibition in the world. In a twilight room ‘X’, a nude created from resin and curled as if bathing with face and knees ethereally illuminated was a highlight. So whether you prefer detail or smooth lines, the human form is celebrated at the Royal Academy this summer.

HOLIDAY ACCOMMODATION

**Antigua:** Spacious 2 bedroom villa for rent, sleeps 2/5. Panoramic views overlooking Caribbean Sea. Fully equipped, A/C, maid service. Yards from beach, watersports, restaurants, bars and facilities. Tel: 01963 220778; www.hummingbirdantigua.com

**England, Co Durham:** Grade II listed cottage in the heart of Weardale in Stanhope, Co. Durham. Sleeps 4. Central village location. Great base for walking and cycling. Tel: Julie on 01207 529090 or email: j_cox@talk21.com

**England, North Yorkshire:** Traditional village cottage in Gunnerside. Sleeps 4-6, fantastic views, beautiful walking countryside, pub and cafe. 100 yards, short breaks available, pets possible. Tel: 01223 894434; email: emalmaris@doctors.org.uk

**France, Dordogne:** 5 bedroom villa with pool in valley overlooking Dordogne River. Local waterports, horse riding, tennis, golf, pre-historic caves, chateaux and beautiful villages; from £549 per week; Tel: 01249 444575; email timothyandhannah@ntlworld.com

**France, Languedoc:** 2 bed villa; private pool; June-Sept); minutes to beach, shops and restaurants; horse-riding, cycling, boating, mountain walking; Airports within easy reach; from £250pw; Tel Kate or Les.busse@medinet.co.za

**France, Provence:** 4 cottages and a cabanon with central pool, can be rented individually or together. Sleeps 14-20 total (2–4 each). Sea 6 miles away. Tel: 02079120884; email: burrill@cottagesinprovence.co.uk

**Greece, Paxos:** Ionian island. Old converted olive press. Sleeps 3. Secluded and quiet. Large patio and BBQ. 10 minute walk to village and beach. Available July and Sept - £450/week. Tel: 0116 2548475.

**Italy, Florence:** Georgian flat next to Ponte Vecchio. 1 double,1 single. All mod cons. air con. £500 per week. Tel: 07773 775852; email profcdan@aol.com.

**Portugal, Algarve:** Carvoeiro, luxury 3 bedroom villa with heated 9m private pool. Sleeps 6. Two bathrooms. Amenities within 10–15 min walk. Fantastic beaches. Tel: Mel Jones 01248 716991; www.villaoleadores.com

**Portugal, Algarve:** Tivemace apartment, sleeps 6. Modern kitchen, pool, entertainment. 5 mins to beaches, restaurants, shops and golf course. Price negotiable. Tel: 0151 932 1817 or 07850 559928.

Anatomical drawings by Benjamin Robert Haydon
Royal Academy of Arts, Burlington House, Piccadilly, London W1 www.royalacademy.co.uk
Exhibition is free and runs until 21 October
Stage of consent

Actors from the National Theatre’s Theatreworks programme were used as part of the ongoing consultation process for consent guidance. Jane O’Brien of the GMC’s standards and ethics team tells GMCtoday why

What has the GMC learned from this?
The play threw up several issues around communication between doctor, patient and carer in the time before final agreement is given to a procedure. These included: whether patients with fluctuating or diminished capacity should be able to talk to doctors without carers present; how much information patients want, especially about risk, and avoiding causing distress; plus the importance of recognising the carer’s role and needs. A key overall message was that giving consent was a process, likely to take place in several discussions, building up patients’ knowledge and understanding so that they were able to make a decision.

Isn’t it quite unusual to use actors in a consultation?
We certainly haven’t done it before. We are currently revising our guidance on consent and we wanted to find new ways of engaging with the GMC’s stakeholders. With drama, you can make issues come to life so much more, and interest patients who might not respond to written consultations. The idea was that half the audience for the play workshops was made up of doctors and half of patients and their carers. The actors act out a short play, then the audience is invited to participate in a second run-through, commenting on what is happening and taking the place of the actors where the situations don’t seem right to them.

What was the scenario of the play?
A man who has had Alzheimer’s for three years goes with his wife to see their GP. They are concerned they have lost a letter from their hospital about an appointment for a gall bladder scan. The action then moves to A&E where the patient is in pain, and finally to a hospital ward, where a consultant tries to persuade the patient to have surgery, while the patient becomes more confused and distressed.

Why concentrate solely on dementia?
Our advice from Theatreworks was that the more narrowly-focused the play was to the audience, the more the audience would have been able to make a decision. Isn’t it quite unusual to use actors in a consultation?

So how did the play help?
The project was intended to bring patients, doctors and carers together, to discuss what patients want and need in making decisions, and what it is practical for doctors to provide. We will be analysing carefully all the issues raised at the events, and use them with other responses to the consultation when we prepare the guidance for publication. It will influence the way the final guidance looks. It can’t be a ‘tickbox’ approach just saying ‘we did a consultation for three months.’

We would like to hear your views on the draft guidance. Information about the consultation is at www.gmc-uk.org/guidance/news_consultation

GMC guidance and the Mental Capacity Act 2005
In the last issue of GMCtoday we promised to provide a list of paragraphs in our published guidance which are clearly out of date, following implementation of the Mental Capacity Act for England and Wales. This list only relates to the main booklets which have not been updated since 2005. Anyone with queries about this, or about how the Act affects other GMC guidance, can contact standards@gmc-uk.org for advice.

Seeking Patients’ Consent (1998)
→ Withholding information – para 11
→ Mentally incapacitated patients – para 21
→ Advance statements – para 22
→ ‘Best interests’ principle – para 25
→ Consent to research – para 37

Research (2002)
→ Assessing capacity – para 45
→ Adults who lack capacity – para 47–48

Withholding and withdrawing life-prolonging treatments (2002)
→ Adult patients who can decide for themselves – para 13
→ Adult patients who cannot decide for themselves – para 14–15
→ Assessing capacity to decide – para 51–52
→ Assessing the patient’s best interests – para 55
→ Resolving disagreements about best interests – para 59
→ Children – para 71

The legal background – appendix

New guidance
Available from the end of July on the A-Z index or ‘supplementary guidance’ on the good practice pages of www.gmc-uk.org

Guidance for Expert Witnesses
Explains how the duties set out in Good Medical Practice (GMP) – to act honestly, promptly and within the limits of professional competence - apply to expert witnesses. Provides links to sources of legal advice.

Guidance on Writing References
Expands on paragraph 19 of GMP, addressing ethical and legal questions for doctors asked to write references for colleagues. Includes advice when there are concerns about a colleague’s competence, performance or conduct.
In October 2005, an allegation was received that a registered doctor had a bogus medical qualification from a UK-based private medical school, then called St Christopher’s College of Medicine, Luton (now named St Christopher Iba Mar Diop College of Medicine, Luton). The GMC investigated and, within 24 hours, acceptance of the degree was suspended and the doctor’s registration was reviewed – and subsequently withdrawn.

An investigation by the BBC revealed that the school was issuing a primary medical qualification that had been accepted onto the World Health Organisation (WHO) World Directory of Medical Schools. At the time, inclusion on this list was essential for acceptance by most international medical regulators, including the GMC.

But affiliations between the school and an African establishment – St Christopher’s College of Medicine in Dakar, Senegal – were based on false claims and some students at the UK school had dubious academic pedigrees. One had studied a two-year element of a medical degree overseas but took over six years to do so, leaving after failing end of year exams. The same student then transferred to a Baltic state medical school, studying on and off for a further six years, including 114 hours spent on a diploma in hypnosis. They finally transferred to the UK ‘medical school’ where, 12 months later, they attained their MBBS and attended a graduation in New Jersey. In other words, the Senegal degree was eventually awarded in the US.

The hurdle of passing the Professional and Linguistic Assessment Board (PLAB) test – compulsory for graduates with degrees awarded outside the UK and European economic area – prevented others from the school getting onto the register, so patient safety was maintained.

The GMC’s investigation also revealed a handful of other private UK-based medical schools claiming similar overseas affiliations. These so-called ‘squatter schools’ were found by the GMC to lack accreditation and were using their split-site arrangement as an opportunity to not carry out quality assurance of the degrees.

Some students claimed to have spent over £100,000 on their worthless education. Many left their school and transferred to other establishments, while some left medical education altogether.

### Some students claimed to have spent £100,000 on their worthless education

The GMC website was amended to show the schools deemed unacceptable for registration in the UK and the GMC reviewed its existing approach of accepting medical degrees listed on the WHO Directory. Other concerns included degrees:

- conferred after a course of study undertaken wholly or substantially outside the country that awarded the medical degree
- which were much shorter than a UK degree. For example, one applicant had obtained a medical degree after only one year’s study
- obtained after a correspondence course
- issued by organisations that appear to have no physical address – making it very difficult to verify that the doctor actually obtained a degree

With no suitable alternative to the WHO Directory immediately available, and the prohibitive cost of assessing over 2,000 degrees, the GMC revised its criteria for an acceptable overseas degree. Since 1 October 2006, in order to be acceptable for UK registration, an overseas primary medical qualification must have:

- been awarded by an institution listed in the WHO Directory or otherwise accepted by the GMC (those from the WHO Directory that it does not accept are listed on www.gmc-uk.org)
- been awarded by an institution that has a physical address included in the WHO Directory
- been awarded after a course of study comprising at least 5,500 hours (or four years’ full-time equivalent study)
- not involved a course of study undertaken wholly or substantially outside the country that awarded the primary medical qualification
- not involved a course of study undertaken wholly or substantially by correspondence

In this case the GMC acted to make exploitation of medical students in the UK less likely. The new criteria, among other checks, help ensure only suitably-trained doctors gain registration. In doing so we help reinforce our purpose which is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.