15 GMCtoday
September/October 2007

General Medical Council

Seeing eye to eye

GMC launches new 0–18 guidance for all doctors

Observer Columnist Jasper Gerard gets party political *p12*

Professional behaviour, new guidelines for medical students *p11*

Sir Graeme Catto
President, GMC

Regulation, like medicine, is a dynamic process – it must not stand still. It must be scrutinised, challenged and improved to ensure it takes account of the needs of our changing society and the changing healthcare environment

Any proposals for change have to be carefully thought through and thoroughly communicated. This edition of *GMCtoday* sets out a number of policy areas where we are undertaking exactly that process to ensure we have an effective regulatory framework which will help doctors to continue to deliver top quality healthcare in this country.

Like all regulators, the GMC needs to look to the future to anticipate long-term challenges. This is why we are committed to a strong evidence base for the future development of regulation. For example, we recently embarked on a unique partnership with the Economic and Social Research Council's (ESRC) Public Services Programme to fund a programme of independent, peer-reviewed, public domain research focused on medical regulation. A number of highly talented research teams across the UK will shortly be embarking upon research projects examining some key issues for medical regulation.

Previous research has shown that international medical graduates (IMGs) are comparatively over-represented in referrals to the GMC from the NHS and other public bodies (as opposed to complaints from individuals), and at the various stages of our fitness to practise procedures. While this pattern has long been recognised, it has not yet been explained. So, as part of the GMC's commitment to diversity and to promoting equality, an important aspect of this ESRC research programme will be to look specifically at why IMGs and doctors from black and minority ethnic backgrounds are subject to complaints, and how they are handled across the sector, including by other public bodies.

On page seven of this edition of *GMCtoday* we explain how we will soon be asking all doctors to provide us with data about their ethnicity and whether they are currently engaged in clinical practice. This will help us meet our commitment to operate a system of regulation that is fair, objective, transparent and free from unlawful discrimination. It will also inform the ESRC research programme and help to point to conclusions in this particular context.

The full programme of ESRC projects will report by 2009 at which time all the findings will be published. In the meantime, through *GMCtoday*, we will continue to update you on the progress of the research programme. We have further information on the GMC website and would welcome any comments or contributions you want to make to these research programmes.

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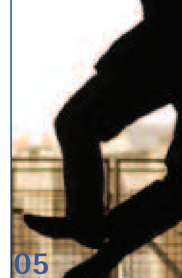

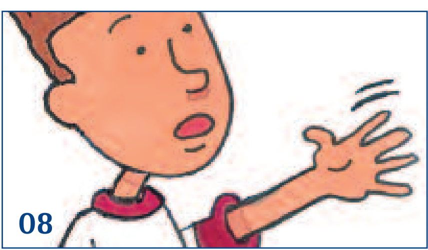

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General Medical Council

Regulating doctors
Ensuring good medical practice

Vision

The GMC's vision is to be recognised as delivering and safeguarding the highest standards of medical ethics, education and practice, in the interests of patients, public and the profession.

The views expressed in articles contributed by external authors are those of the authors and are not necessarily shared by the GMC.

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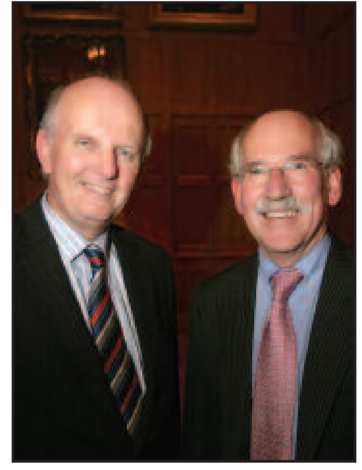
A first for Northern Ireland



The GMC's governing Council met in Northern Ireland in September demonstrating its commitment to engage with the devolved administration following the establishment of a Northern Ireland office.

The Council members met in Belfast where the agenda highlighted continuing work to translate good medical practice in order to provide an effective framework for appraisal and assessment. They also discussed: an independent audit carried out by King's College, London which reflected positively on the GMC's processes for dealing with concerns about doctors; how to enhance engagement with medical students; and the implementation of new procedures for consensual disposal.

Professor Sir Graeme Catto, GMC President commented that the GMC Northern Ireland office has only been open a year and a half but had already built strong relationships with the local health community. He added: *'This allows the GMC to engage directly with local audiences, taking their views into account when developing policy and guidance.'*

Health Minister, Michael McGimpsey MLA (pictured above with Sir Graeme) said: *'The GMC has made significant moves in recent years to reflect the devolved arrangements within the UK. In the year since the formal opening of your local office, the interaction and engagement with the GMC locally has been mutually beneficial and I fully expect this to continue and develop further.'*

Supporting disabled medical students

The GMC is leading a project to develop guidance for medical schools on encouraging the entry of disabled people into medicine.

Development of the guidance, which will be published by April 2008, is financially supported by 11 medical schools and match-funded by the Department of Innovation, Universities and Skills.

This project takes forward the GMC's commitments to promote equality and diversity and to work together with other organisations.

A draft of the guidance will be considered at a full day consultative conference, held at The British Library, on Friday 7 December. Places are limited, so to register your place contact Karen Thompson at **kthompson@gmc-uk.org** or call 020 7189 5285.

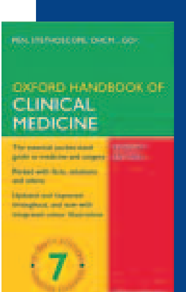
Please visit the gateways project link at **www.gmc-uk.org/education** for further details.

Accurate job references are crucial to patient safety – new GMC guidance

Most professionals are called upon at some point in their career to write references for their colleagues. However much a chore, most doctors realise that accurate and honest references are the key to prospective employers recruiting the right person for the job, and that inaccurate accounts could lead to an unsuitable candidate being appointed, which in some cases could put patients at risk of harm.

Doctors have told us that they would welcome additional guidance in this area. New GMC guidance published online this autumn addresses common questions about the information that doctors should include when writing references for professional colleagues, providing useful clarification about what the GMC expects of doctors in this area. *Writing References* is now available online at: **www.gmc-uk.org**

Three copies of the 7th edition of the *Oxford Handbook of Clinical Medicine to be won.*



Did you know that all the guidance in the GMC's *Good Medical Practice* is available online?

Visit www.gmc-uk.org and tell us what's missing from the following statement:

Good clinical care must include adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), and where necessary examining the patient.

Email your answer with 'GMCtoday competition' as your subject line to **gmctoday@gmc-uk.org or send a postcard to** GMCtoday, 350 Euston Road, London NW1 3JN.

The first three correct answers picked at random on 20 October win. The Editor's decision is final.

Congratulations to Sarah Ashton who won last month's prize.

Countdown to new registration framework

19 October 2007 sees the launch of our new registration framework. This major step in our continuing reform programme means both public protection and equality of treatment for doctors – and greater clarity for patients and employers.

Limited registration, which currently applies only to international medical graduates (IMGs), will be abolished. IMGs will still satisfy rigorous criteria, but will move straight to the same types of registration as UK graduates (UKGs), and will no longer need a job offer beforehand.

From this date UKGs and IMGs granted full registration for the first time and taking up a new post, or returning to the register after a prolonged period out of UK practice, must work initially within organisations we have approved as suitable for doctors new to full registration.

To find out more visit **www.gmc-uk.org/doctors/new_framework** or email **nrf@gmc-uk.org**

The civil standard of proof

The GMC is presently consulting on the standard of proof used at Fitness to Practise Panel hearings, when panellists are making decisions on disputed facts. The purpose of the consultation is to seek views on how the move to the civil standard can best be implemented.

Council member Gillian Camm, who chairs the GMC's Fitness to Practise Committee, put the proposed changes to the standard of proof into context for *GMCtoday*. She was keen that doctors also see them within a wider programme of reforms. She explained: *'We are not proposing to make any changes as far as the burden of proof is concerned. In GMC proceedings it has always been the case, and will remain so, that it is for the GMC – which makes the allegations – to prove them to the satisfaction of the Panel; not for the doctor to prove they are untrue. What we are proposing, however, is that – for the first time – we will make explicit reference to the standard of proof in GMC fitness to practise rules. We are seeking views on the wording of the proposed rule. We have also drafted guidance on the application of this rule and we are including this guidance as part of the consultation.'*

In civil proceedings, the standard of proof is proof on the balance of probabilities; a fact will be established if it is more likely than not to have happened. However, the civil standard of proof is not a rigid criterion by which facts are to be judged. It is essentially flexible in its application and is to be tailored to the facts of any given case. It is often said that the more serious the allegation the more cogent will be the evidence required.

The White Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*, published earlier this year, confirmed the Government's intention that the civil standard of proof should be the common standard across all health professional regulators. It is already used by a majority of those regulators. What the Government has said is that it should be included in the Health and Social Care Bill – which is part of the draft legislative programme for 2007/2008.

The standard of proof has no part to play in a number of aspects of GMC fitness to practise proceedings. Gillian Camm explained: *'It's important to remember that the standard of proof only has relevance when the facts are disputed. It will not be relevant for Interim Orders Panels which make no finding of fact. Nor will it be relevant where there is no dispute as to the facts where, for example, the doctor has admitted the allegations or where the evidence before the panel or committee relates to a criminal conviction or a determination by another regulatory body.'*

The standard of proof becomes relevant only at the stage which deals with factual allegations.

The civil standard of proof 'is not a rigid criterion by which facts are to be judged. It is essentially flexible and is to be tailored to the facts of any given case'

Leading Counsel has advised us that the civil standard of proof *'is not a rigid criterion by which facts are to be judged. It is essentially flexible and is to be tailored to the facts of any given case. As is often said, the more serious the allegation, the more cogent will be the evidence required.'*

Concerning the distinction between the criminal and civil standard of proof, the point is made that this *'is in practice rather more apparent than real.'* The advice also establishes that in the most serious cases, doctors should find that the *'application of the civil standard with the flexibility appropriate to the seriousness of the allegation and of the consequences for the practitioner should lead to the same results as would application of the criminal standard.'*

The proposed changes to the standard of proof can also be placed alongside other changes the GMC is introducing – as Assistant Director, Fitness to Practise, Una Lane explained: *'We would like to set this consultation in the wider context of ongoing fitness to practise reforms, picking up the emphasis in the White Paper on helping doctors retain or regain their fitness to practise and seeing the fitness to practise process as a gateway to rehabilitation, where this is possible and realistic.'*

One example of this is the new legislative provisions which are already in place to extend the GMC's facility for disposing of cases consensually. This can happen at the investigation stage of its procedures, by agreeing binding undertakings with the doctor rather than referring for a public hearing. These provisions are due to come into force later this year.

The GMC consultation about the standard of proof is running from 20 August 2007 to the end of October 2007. As part of the consultation there are a series of workshops planned for early October in London, Belfast, Cardiff and Edinburgh. The consultation documents are also available to view online at **www.gmc-uk.org**.

Working patients are healthy patients

Dr Nerys Williams from the Department for Work and Pensions (DWP) appeals to doctors to get the long-time sick back to work

Obtaining and retaining work can be a challenge for people with health conditions. In May 2007 DWP launched an undergraduate competency framework for medical students on the links between work and health which has been developed with the Faculty of Occupational Medicine and Cardiff University. This framework is intended to encourage future doctors to look at the ways they can offer positive support to patients with health conditions. This support would include a positive consideration of what a person *can* do not just what they cannot do.

Of course, at times discussions around work and sickness can be difficult. If we are to improve the clinical and vocational outcomes for a patient, it is essential that the doctor communicates effectively on the pros and cons of working, when to return to work and what sort of work would be appropriate.

A recent independent review of the scientific evidence around health and work has shown that work:

- can be therapeutic for people with both mental and physical health problems and can help promote recovery
- minimises the risk of the physical, mental and social effects of long-term unemployment
- reduces social exclusion and poverty
- can improve the quality of life and well-being.

Conversely, the review described a strong association between worklessness and poor physical and mental health and well-being with strong evidence that unemployment leads to:

- 20% excess mortality
- two- to three-times the risk of poor general health
- two- to three-times the risk of poor mental health.

The review also found that the longer a person is off work, the less chance that they will ever return.

The authors concluded that work is generally good for health and well-being in the majority of cases

The review does contain some provisos – that research is generally about group effects, that within groups a minority of people may experience contrary health effects, and that the beneficial health effects are dependent on the nature and quality of the work undertaken. But overall the authors concluded that work is generally good for health and well-being in the majority of cases.

This is true for people with disabilities, and for most people with common mental health problems (such as stress, anxiety and depression). For people out of work, getting back into employment improves self-esteem and general physical and mental health, and reduces psychological distress and minor psychiatric morbidity.

There are some clear messages here for doctors:

- that advice to stay off work potentially can have serious long-term consequences in terms of increased health risks
- that return to work can improve a person's health condition – for example, by ending social isolation
- that the right type of work can have a positive impact on a person's recovery and general well-being.

Resources

'Is work good for your health and well-being?' – an evidence review.
G. Waddell, K Burton.
The Stationery Office. London 2006.

The competency framework can be viewed at **www.facoccmed.ac.uk** under resources for medical schools.

Improving access to surgery survival rates

Last April, the Healthcare Commission launched a unique new website. For the first time, patients were given access to survival rates for heart surgery by hospital and by individual surgeons. It is hoped the project will eventually provide a benchmark for other conditions to follow. Here Anna Walker outlines some of the lessons learnt

Anna Walker
Chief executive at the Healthcare Commission

Information about performance in the NHS is the foundation stone of our system of standards and quality. In the past, there have been great difficulties in collecting this information for heart surgery. Cardiothoracic surgeons therefore have a lot to be proud of, in fact, now this information is available to patients.

In 2005, we got together with the Society for Cardiothoracic Surgery in Great Britain and Ireland to develop a website which made information collected in the Society's audit programme available to the public.

Getting the surgeons on board

The first and, arguably, most important step was ensuring the process won the confidence of the clinicians involved and that this continued. Most clinicians are happy to be judged by their results but, quite rightly, want the information to be accurate and fair.

Crucially, the information used on the cardiac website allows survival rates to be calculated for every unit, and indeed for every surgeon, taking into account the range of predisposing factors known to affect the outcome (the so-called 'risk adjustment' covering, for example, a patient's age and the gravity of the condition).

Some of the data required to adjust for risk are quite technical and are best collected by surgeons. In fact, unless clinicians are involved in collecting the data, ensuring their accuracy and agreeing and developing risk assessment methods, the results will lack credibility and validity. In effect, without the doctors on board, it won't fly.

Managing the information

The website is primarily aimed at patients and the public. The information must therefore be relevant to them and easy to understand, without compromising its integrity.

We worked closely with cardiac surgery patients and the general public to help us develop the site and check its content and design as we progressed, and we continue to do so. But there is an important role, for general practitioners for instance, in helping with interpretation for those who do not understand the data.

The benefit of publishing the survival rates for individual surgeons was a contentious issue.

On the one hand, it is argued that much surgery depends on complex teamwork; outcomes are also affected by what happens before and after the surgery; and there is always a risk that surgeons who have, by chance, had a run of poor results will avoid high-risk patients, despite the existence of risk adjustment.

On the other, many surgeons wish to publish their own results and it is their prerogative.

The future

So 'what next'? Many assume this groundbreaking initiative in providing accessible information to the public will soon be seamlessly extended to the whole of healthcare. It won't.

There are several reasons why cardiac surgery has been the first discipline to succeed in this endeavour. First, the desired outcomes of surgery are readily defined and measured, and are relatively immediate. Second, there is a small number of possible operations, each of which is fairly standard. Lastly, the seriousness (and cost) of cardiac operations fully justifies the effort and cost of collecting and analysing complex outcomes information.

While some of the criteria can be applied to other disciplines, particularly those involving major surgery, there are many healthcare fields that will struggle to produce meaningful outcome information. Patient-reported outcome measures will help, but there will always be debate over the right point on which to capture these in the pathway of care, especially for chronic conditions that can stretch over decades.

But the trend has begun and the Healthcare Commission will play its full part. We have just completed our first annual update of the cardiac website, and we are continually evaluating the site to understand how patients and the public are using its information.

The website, complete with new 2005/06 data can be found at: **http://heartsurgery.healthcarecommission.org.uk**

Diversity & ethnicity

The GMC will soon be asking doctors for help collecting comprehensive ethnicity and limited practice data

This is a huge and important task. It will help the GMC to ensure our processes and procedures are fair, objective, transparent and free from unlawful discrimination. The GMC has statutory duties under the Race Relations Act and other legislation which this data collection will help to fulfil. It should also smooth the path towards the introduction of licensing.

The GMC already holds ethnicity data for some 30% of all registered doctors in the UK. Our aim is to fill the gaps in our knowledge of the working doctor population.

Once this comprehensive information is gathered it can be used to ensure any future analysis of diversity issues is both accurate and proportionate. As Sir Graeme Catto has mentioned in his column on page 2, such information will be an invaluable tool to help the independent academic research commissioned from the ESRC – one part of which will be looking at why international medical graduates are disproportionately represented in the GMC Fitness to Practise procedures.

Council member, Dr Edwin Borman, Chair of the GMC's Committee on Diversity and Equality and Chair of the BMA's International Committee, sets out why this exercise is so important, and what you can do to help

You may soon have the chance to help the GMC in its work to eliminate unfair discrimination

We are committed to ensuring our processes and procedures are fair, objective, transparent and free from unlawful discrimination.

We will soon be carrying out the first comprehensive exercise aimed at consolidating diversity data for the medical profession, and your help is needed to make it a success.

If we do not have access to current ethnicity data for you, we will be sending you a form to complete this autumn. I would urge you to look out for it. While I know that you will have completed such forms many times in your career, no single organisation holds the kind of data we'll be asking for. So currently it's not possible to provide with accuracy even the most basic diversity data on doctors practising in the UK.

That's a loss for all of us, because concerns about unfair discrimination have dogged the medical profession for far too long. The GMC is committed to doing all it can to ensure that not only is unfair discrimination definitively buried, it is *seen* to be definitively buried.

That's why we will be asking you for ethnicity data. Once we hold this information, we will be able to deal with the concern that, as a group, doctors who have qualified abroad are disproportionately subject to Fitness to Practise procedures, and are more likely to be referred to the GMC by public bodies, such as their employer.

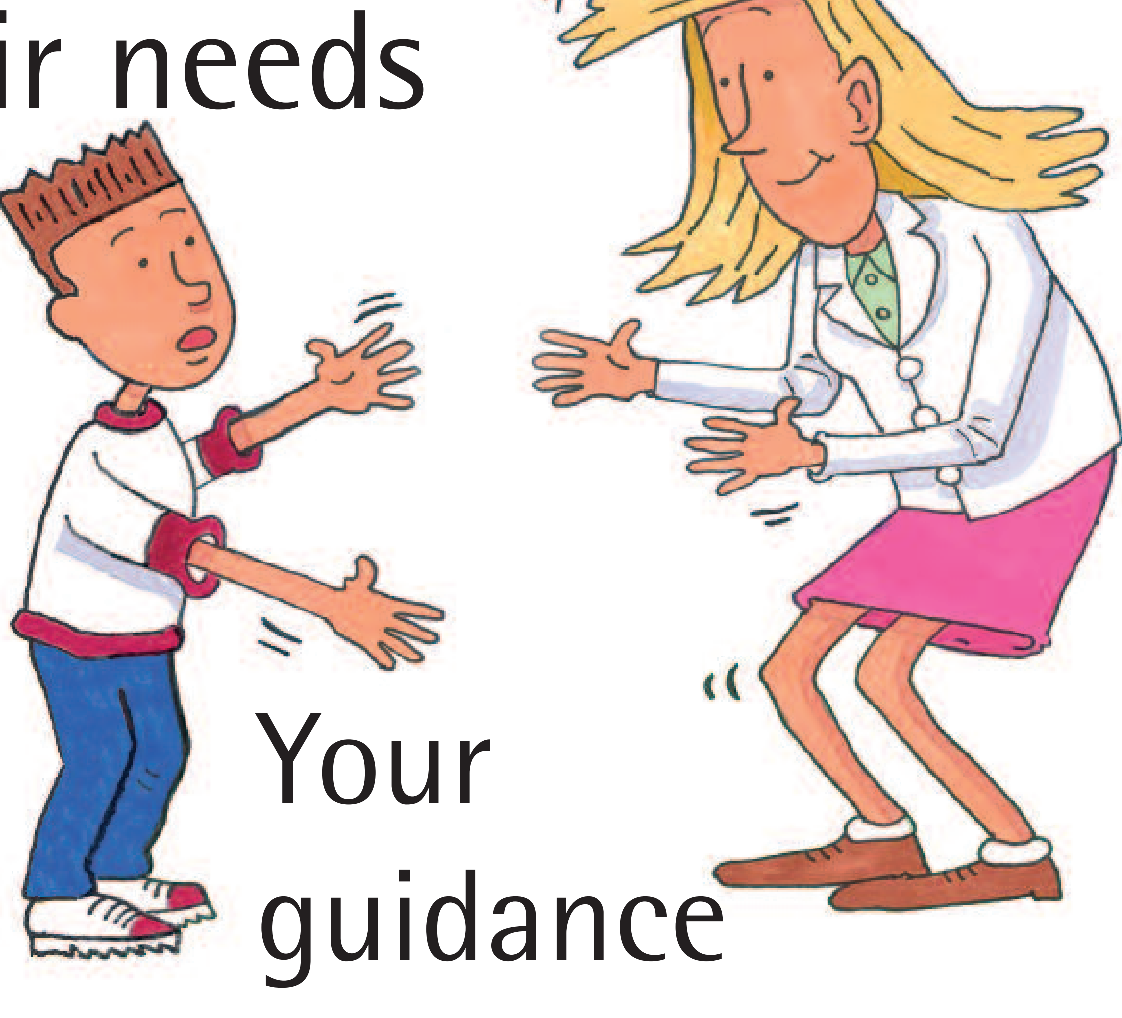
The medical profession is well placed within UK society to demonstrate that multiculturalism works

We are also keen for the GMC, as a leading regulator, to set an example. The medical profession is well placed within UK society to demonstrate that multiculturalism works. We're all comfortable with working with colleagues from all parts of the world, providing the best possible care for patients, whatever their background. This data-consolidation process will provide an opportunity for the medical profession to show how good it is at recognising the importance of these issues. I'd like to assure you too that the GMC will hold your data in a manner that is robust, confidential, and has been recognised as such at ISO 27001 level.

So, if we approach you, please do fill in your form, and send it to the GMC, and encourage your colleagues to do the same. With your help, this really important, yet near-impossible task becomes do-able. ”

The GMC is committed to taking the utmost care with your data. It will remain confidential, and will not be available on the medical register or in any publicly available database. We are BSI accredited at ISO 27001 level – the world's leading standard for Information Security – and we keep security under constant review.

Their needs



Your guidance

Earlier this year the GMC sought the views of doctors, young people and children to develop comprehensive guidance for doctors which is now published and introduced here by Council Member Dr Rosalind Ranson, who chairs the working group that developed the guidance

Do you ever see children or young people as patients? Do you have patients who care for (or are cared for by) children? Might some of your patients pose a risk to children? Do you ever undertake medical research?

As a doctor, if you've answered yes to any of these questions, the GMC's new publication, *0–18 years: guidance for all doctors*, enclosed with this issue of *GMCtoday*, will be vital reading. In fact, as the title suggests, it's for all doctors, so please do take the time to read it.

The guidance represents the culmination of extensive engagement and consultation with both children and young people and their doctors to ensure that all the guidance is accurate, relevant and helpful for busy doctors making difficult decisions in patients' best interests.

All doctors have a role to play in promoting children's and young people's welfare. If you're a GP or paediatrician, that will be obvious. But doctors caring for parents, grandparents and others who care for (or are cared for by) children or young people should have regard to their welfare too. Many doctors care for patients who may pose a risk to children and young people; so, while the patient is the first concern, doctors must also consider and act in the best interests of children and young people.

Children and young people need to be protected from harm. They rely on others for their well-being and should be helped to reach their potential. Doctors in a variety of roles can do this, whether or not they routinely see children and young people as patients.

But children and young people are also individuals with rights. As they mature, this means involving them more in decisions that affect them, until they can make decisions for themselves, while in most cases encouraging the continued involvement of parents. It means listening to what they have to say. It means respecting their decisions and confidences, while understanding when, exceptionally, the loss of trust or other harm that may be caused by overriding children's views will be outweighed by the benefits to their health or safety.

The GMC's new guidance will help doctors balance these competing interests and to make decisions that are ethical, lawful and in the best interests of children and young people.

The guidance addresses many major and difficult questions that doctors dealing with children and young people may face at some point during their working lives. For example:

- Should children be involved in research that offers them no therapeutic benefit when they lack the capacity to consent? What risks are acceptable?
- Should underage sex be reported to the police or social services? What indicators of harm will help you decide?
- Is circumcision of male children for religious or cultural reasons acceptable?

Case study 1

A two-year-old boy's parents are divorced. He lives with his mother, who says she doesn't want the father to know about her own or their son's medical care. If the father asks to see his son's medical records, what should the doctor do?

Those with parental responsibility should be allowed to have reasonable access to their children's records if the child or young person lacks capacity or consents and such access is not against their interests.

Divorce does not affect parental responsibility and doctors should usually allow both parents reasonable access. The mother's wishes should be clearly ascertained so the doctor can decide whether it is against the boy's interests for his father to see his records. If not, the doctor should allow the father to see the boy's records in the normal way.

Case study 2

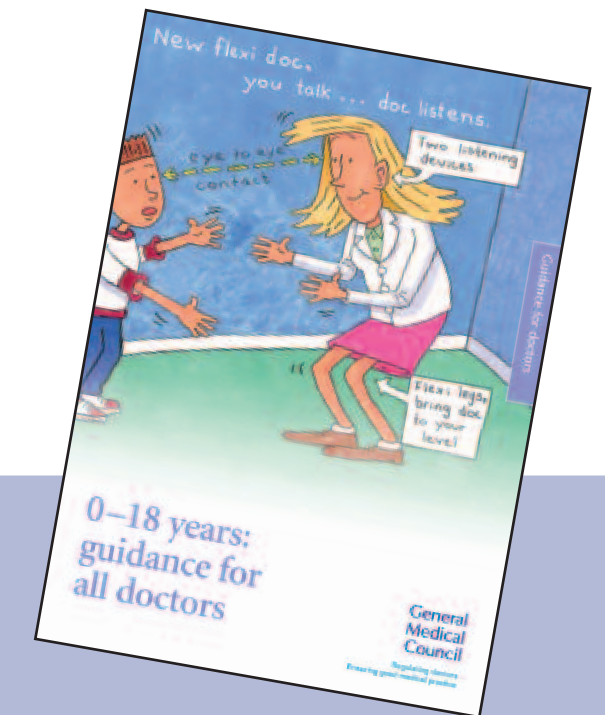
An adult patient says that a teacher abused him as a child. He is keen to put the past behind him and certainly doesn't want anyone else to know what happened. Should the patient's confidence be respected or should the doctor inform relevant other parties?

The importance and benefits (to children who may continue to be at risk) of sharing information should be explained, and the patient's consent to do so sought.

Doctors should understand that the patient might fear blame or feel ashamed or have had bad experiences in the past of confiding in others.

Disclosures without consent inevitably damage the trust between doctor and patient as well as society's interest in maintaining that trust.

While doctors' first concern must be the care of their patients, there are times when the safety of others must take priority. It is important that steps are taken to protect children and young people from serious harm; so in this case the doctor must inform the appropriate authority of any concern that children or young people may be at risk of abuse. The doctor must continue to offer the patient care and support, recognising the harm the disclosure may have caused to their relationship.



0-18 years: guidance for all doctors is the latest publication to supplement *Good Medical Practice* (GMP). The current edition of GMP was published in November 2006, following a two-year review and consultation with the profession, employers, patients and the public.

GMP is the GMC's core guidance for doctors. It sets out the principles and values on which good practice is founded. As such, it contains little in detail about consent, confidentiality or research, for example. These topics, along with medical management and withholding and withdrawing life-prolonging treatments, are explored in more detail in separate booklets published by the GMC.

These are sent to all doctors on the register upon publication (or when the doctor registers). They're also all available on the GMC website, where GMP appears with a number of additional features, including links to fitness to practise decisions illustrating the principles with real life cases, and guidance from other statutory bodies.

And the website contains other useful short guides on issues as diverse as reporting gunshot wounds to maintaining boundaries, from raising concerns about patient safety to making recordings of patients – all presented in a succinct, easily digestible format.

Go to **www.gmc-uk.org/guidance** to find the published guidance. You'll see information about important changes and consultations on new guidance and reviews of existing publications.

The cover for the 0–18 guidance was designed by Paul McAleenan, aged 13, from Northern Ireland, who was the winner of the poster competition that we ran in conjunction with the consultation earlier in the year.

GMC and SPSO smooth way for health complaints

The GMC and the Scottish Public Services Ombudsman (SPSO) have taken a step forward in co-ordinating investigations into complaints about doctors. In August, ombudsman, Professor Alice Brown, and the Chief Executive of the GMC, Finlay Scott, signed a Memorandum of Understanding (MoU) on co-operation at GMC Scotland's offices in Edinburgh.

The MoU commits both organisations to co-operate around the investigation of complaints. It formalises the current arrangements where, if the GMC or the SPSO gains information which may assist in or trigger an investigation by the other, then that information is shared accordingly.

The MoU also commits the GMC and SPSO to share information on trends and issues in casework around complaints about doctors and to collaborate on informing other organisations about their work.

Finlay Scott, Chief Executive of the GMC said: *'Both organisations recognise the importance of working together to share information and best practice in the interests of patient protection and public safety in Scotland. This will allow for greater consistency of decision making and information exchange and contribute to the development of the distinctive Scottish system for dealing with health complaints.'*

Ombudsman Alice Brown stated: *'Complaints provide an invaluable perspective on patient experience and our investigations can draw attention to issues that other organisations are best placed to resolve. This agreement strengthens our mutual co-operation and will benefit individual members of the public who have cause to complain and, more widely, drive improvement in the delivery of NHS services.'*

Help us develop our tests for physicians and emergency medicine doctors

Would you like to help the GMC to ensure the instruments we use to assess potentially poorly performing doctors remain pertinent and up to date?

We need practising doctors of good standing to take a written test and a set of clinical skills test in an Objective Structured Clinical Examinations (OSCE) format. Volunteers will receive feedback about their own performance in the tests and CPD points. A fee of £350 will be paid, plus travel expenses (but not overnight accommodation). Your commitment will be for a single day lasting from 9:30 to 4:30 at our Euston Road office in London.

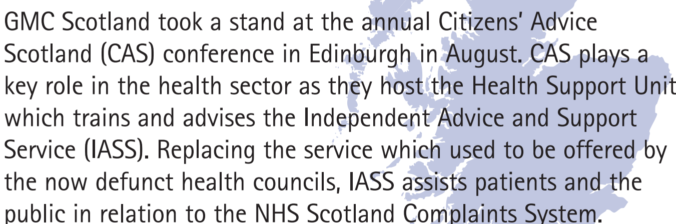
Available sessions:

Emergency Medicine, 5 & 6 Nov and 11 & 12 Dec 2007.

General Medicine, 7 & 8 Nov and 13 & 14 Dec 2007.

This exercise is being arranged for the GMC by the Academic Centre for Medical Education (ACME). If you are interested or require further information, please contact Joanne Turner at ACME by email at **t.acme@medsch.ucl.ac.uk** indicating which day you would be interested in attending.

Citizens' Advice Scotland annual conference 2007



GMC Scotland took a stand at the annual Citizens' Advice Scotland (CAS) conference in Edinburgh in August. CAS plays a key role in the health sector as they host the Health Support Unit which trains and advises the Independent Advice and Support Service (IASS). Replacing the service which used to be offered by the now defunct health councils, IASS assists patients and the public in relation to the NHS Scotland Complaints System.

GMC Scotland and CAS have developed a Memorandum of Understanding (MoU) (due to be signed in October) which will allow for a more integrated approach to information sharing and raising concerns.

Jackie Burman, Health Support Unit Coordinator, said: *'I'm optimistic that the new GMC – CAS MoU will help in the process of ensuring that there is a much better and earlier communication process where problems may be arising, whether doctors are working in the NHS or are checking on a person's entitlement to benefits.'*

Cardiff meeting sets agenda for UK-wide regulation

The GMC further emphasised its commitment to four-country regulation in a meeting in Cardiff this summer. Representatives from the GMC were invited by the Chief Medical Officer for Wales to speak to a meeting of all Wales Medical Directors. Also present was the CMO Tony Jewell, the Welsh Assembly Government and key representatives of NHS Wales.

Neil Roberts, Director of Registration and Reform, opened the presentation and emphasised the GMC's commitment to forging even stronger working relationships with employing organisations in Wales, such as the Local Health Boards and the Trusts.

Natalie Drury, the GMC's Head of Welsh Affairs said: *'It is encouraging that the Local Health Board Medical Directors and the GMC in Wales are building closer working relationships. This cements our commitment to four-country working and further emphasises the role of the GMC in working together with doctors' employers to deliver enhanced patient safety.'*

Guidance fit for the future

Tomorrow's Doctors, one of the GMC's flagship guidance publications, is to be reviewed to ensure that it remains fit for purpose

Tomorrow's Doctors sets out the standards for the knowledge, skills, attitudes and behaviours that medical students should learn as part of their undergraduate education. These standards provide the framework that UK medical schools use to design detailed curricula and schemes of assessment. They are also the standards against which the quality of undergraduate teaching and assessments are judged by the GMC's Quality Assurance of Basic Medical Education (QABME) programme.

The review of *Tomorrow's Doctors* will build on the conference held in 2005 on Medical Education – From Here to Where? and the subsequent consultation on Strategic Options for Undergraduate Medical Education. It will consider if the standards set out in the current edition are still relevant and appropriate and will take account of developments in educational theory and research and professional practice since the guidance was last published in 2003.

The first phase of the review will be an informal information gathering exercise that will take place over the next six months. Throughout this period medical schools, students, QABME visitors, employers, patients and the public will be invited to add their input on the key issues involved. The outcomes of this process will then inform the development of a revised draft guidance.

The revised draft guidance on *Tomorrow's Doctors* developed through this process will be published for consideration and feedback during a three-month consultation period commencing in spring 2008.

Professor Michael Farthing, Education Committee member and Chair of the Tomorrow's Doctors Review Group said: *'Ultimately the project will lead to a new, improved edition of* Tomorrow's Doctors *which meets the changing context of the medical education environment and ensures undergraduate medical education continues to provide graduates with a strong foundation for future learning and practice.'*

If you have any views about how the current guidance could be improved, or if you wish to receive information about this review, please contact **tomorrowsdoctors@gmc-uk.org**. Alternatively, please visit our website **www.gmc-uk.org** for updates on the progress of the review.

Are you fit to practise?

New guidance covering the professional behaviour expected of medical students is available as a result of collaboration between the GMC and the Medical Schools Council (MSC)

Back in 2005 a joint working group was set up between the GMC and the MSC to consider how to improve student fitness to practise. Since then the working group has consulted widely and produced joint guidance aimed at medical students and all those involved in medical education: *Medical students: Professional behaviour and fitness to practise.*

The guidance covers the professional behaviours expected of medical students, areas of misconduct and the sanctions available, and the key elements in student fitness to practise arrangements. The guidance addresses fitness to practise concerns only in relation to a medical student's conduct. One of the working group's next tasks is to develop new guidance on students' health and their fitness to practise.

The GMC and the MSC hope that this guidance will promote the professional behaviours expected of medical students and help instil these behaviours. The guidance also aims to help medical schools reach decisions about a student's fitness to practise and in this way develop consistency in approaches to student fitness to practise.

Recent changes in the law have highlighted another important need for this guidance. The GMC now has the legal authority to deny a graduate registration if we are not satisfied that the graduate is fit to practise. Martin Hart, Assistant Director of Education for the GMC explained: *'With the implementation of this guidance we expect that the decisions reached by a medical school would be consistent with those made by the GMC.'*

This guidance is not mandatory for medical schools although their fitness to practise processes will be reviewed as part of the GMC's quality assurance process. Because of this the working group is currently looking into ways to help schools implement the new guidance.

Copies of the guidance have been sent to all medical schools and to other organisations with an interest in medical education. A leaflet about the guidance, highlighting the professional behaviours expected of medical students, has also been distributed to all UK medical students. Visit **www.gmc-uk.org/students** if you would like to read the guidance.

Improving diagnosis of dementia

Professor Clive Ballard

Director of Research for the Alzheimer's Society

Samantha Sharp

Senior Policy Officer, Alzheimer's Society

A view from the Alzheimer's Society

On 10 August, Mrs Justice Dobbs ruled that guidance from the National Institute for Clinical Excellence (NICE) on drugs developed for the treatment of mild to moderate Alzheimer's disease was unlawful and unreasonable because it discriminated against particular groups, including those with a first language other than English, those with dysphasia and also with learning disabilities. The reasons for the ruling included the strict reliance of the guidance on the Mini Mental State Examination and the failure to implement an appropriate process to discharge their statutory duty to ensure equitable access to treatment. She ordered NICE to revise the guidance to remove discrimination.

NICE's decision-making regarding the guidance for people with mild Alzheimer's disease (AD) was not found to be unlawful, despite major inconsistencies and inaccuracies being highlighted in the way in which cost and carer benefit were estimated. The guidance will therefore continue to recommend that cholinesterase inhibitors are only available to people with moderate AD. In addition, the guidance will certainly help people with moderate AD, as the audit standard for treatment will require a four- to five-fold increase in prescribing and will need considerable investment and strategic planning in primary care and secondary care services to enable this to be achieved.

Concerns have been raised about the restriction of treatment for people with mild AD on the drive for timely diagnosis. This is especially important in the context of the National Audit Office report *Improving services and support for people with dementia* which finds that only a third of people with dementia ever receive a formal diagnosis and that fewer GPs now feel confident about diagnosing dementia than in 2004. Worryingly, the unavailability of pharmacotherapy will reinforce these nihilistic views, with a third of GPs already believing that it is not important to look actively for early symptoms of dementia.

There are many benefits from an early diagnosis. From a medical perspective, treatable causes of dementia and factors that exacerbate dementia can be addressed. Of particular importance, the treatment of vascular risk factors has a stabilising effect on the progression of cognitive impairment and functional disabilities in people with vascular dementia and is also beneficial in people with AD. An early diagnosis also enables people to access services and take more control of the future, using tools provided by the Mental Capacity Act 2005, including Lasting Powers of Attorney and Living Wills. Diagnosis while the individual still has capacity also enables them to authorise access for their carer to medical records, which can resolve problems surrounding patient confidentiality.

In less than twenty years over a million people in the UK will have dementia. It is therefore welcome and timely that the Department of Health in England has recently announced the launch of a process to create a National Dementia Strategy. This is a vital step and should develop mechanisms to enable improved diagnosis, treatment and care for people with dementia.

Ooh Matron!

Observer columnist Jasper Gerard looks at this year's party conference season for signs of life

Tony Blair had a comforting bedside manner. There were occasional cries of pain over Labour's NHS medicine which gave us foundation hospitals, the junior doctor debacle and dirty wards, but always Blair could point to Labour's massive cash injection. Conservatives lacked credibility because – as even they now concede – they had underfunded hospitals. And the Liberal Democrats, in seeming to oppose accountability of health professionals, could sound like the political wing of the British Medical Association.

Such an unhealthy political condition will receive the full treatment during the party conference season as all three parties focus on the NHS. Labour will emphasise improvements – as on waiting times – but opposition parties sense the patient is still rather peaky despite all that spending. So they sniff political opportunity. Their diagnosis? Gordon Brown is obsessed by centralised targets, and ignores patients' individual needs.

The most radical conference policy paper comes from Norman Lamb, new Lib Dem health spokesman. He will advocate more patient choice which he thinks chimes with Britain's consumerist society. He will also flesh out ways of increasing local control, lessening the need for Whitehall targets which have arguably produced a greater boost to accountancy than care.

Andrew Lansley, Tory health spokesman, has to be more cautious on choice as Labour slaughters his party whenever it hints at opt-outs for the middle class. He will rule out subsidising private treatment and while he wants more published information about hospital outcomes to make us better informed users of healthcare it is unclear how patients could use that knowledge to receive their preferred treatment. Still, his paper for conference contains the radical proposal that GPs specialise so patients can go straight to a doctor with relevant expertise.

Labour will debate the health secretary Alan Johnson's 'once-in-a-lifetime NHS review', which has prompted weary groans from doctors who suspect it will be the last review until the next one. Johnson's message to conference will be that after junior doctors, Labour's health policy is on the mend and recent changes need time to bed down. But that won't stop other parties hollering for matron...

Jasper Gerard

The Observer

Your feedback and letters

An expert opinion

Your Say

Expert witnesses
A personal view

In his article ('Expert Witnesses: A personal view' *GMCtoday* May), Michael Cohen touched on some important points in relation to medical expert witnesses. But in promoting the achievements of his own Academy of Experts, he appeared to be reflecting the current struggle for power between several organisations of experts rather than getting to the nitty-gritty of what's important in assisting a court. Mr Cohen's three 'key requirements' comprised 'independence, impartiality and integrity'. But there is another, much more important requirement: that the expert is indeed a true expert in his or her field.

This does not just mean being a consultant. It means someone with accumulated and lengthy experience at a high level, someone who has sufficient depth of practical knowledge, and of the limitations and pitfalls of practice, to be able to advise a court from a position of strength. Too often this is missing in those who put themselves forward as 'experts'. For example, new or relatively inexperienced consultants are often tempted to undertake this work in a health service where older, deeper wisdom is being lost at a frightening rate as senior clinicians retire early in despair at our declining health system and the bureaucracy which enmeshes it. All the 'independence, integrity and impartiality' in the world will not make up for this experience. And nor will offering 'training' to experts.

Peter Mahaffey *FRCS, Bedford*

Firm on terrorism

The events in the summer linking terrorist activity to members of the NHS will have far reaching consequences for medical professionals and patients alike.

Patients need to feel reassured that we as doctors have their care and well being as our priority. The cornerstone of good medical practice is that we are 'honest, trustworthy and act with integrity'. It states that our conduct at all times should 'justify our patients' trust in us and the public's trust in the profession'.

We must allow the authorities to carry out their criminal investigations and if any individual is found to be implicated, the GMC must act accordingly to ensure ongoing probity within our profession.

Dr Alexis Bowers, *Hertfordshire*

Where are they now?

There was a great fuss made over the arrival of 30,000 new graduates into their first house officer jobs, as if this would cause some great disruption. When I was a young-ish doctor in this situation, the NHS employed a tribe of dragons – otherwise known as ward sisters. These wonderful people knew their wards inside out and far more than the new doctors. There was no problem with the change-over from the old set of doctors to the new. Where are these dragons now?

Barbara Cowie, *Edinburgh*

Prescribing privileges for retired doctors?

In the revalidation article (*GMCtoday*, May) I find no mention of any policy regarding the issue of prescribing rights of retired doctors. This is of some importance to a few doctors in areas where out-of hours medical services are not readily available. I have no intention of resuming practice, however over the past 12 years the occasions on which I have prescribed have been one or two per year. These have been illnesses among family members and visitors, a few potentially serious if not treated urgently. There was a child concussed from a fall from a horse, and a fellow passenger on a train who had an epileptic seizure. Not all required prescriptions, but one was asked for professional advice. One potential solution would be that retired doctors retain prescribing privileges from a 'limited list', provided that the list was realistic.

J E Cosnett, *FRCP London*

Editor's comment: The White Paper proposed there should be further discussions among interested parties on this issue.

Beyond the nine-to-five

As a newly qualified F1, it is common to feel over-burdened with your new-found responsibility. Gone are those heady student days, when you could down tools willy-nilly, confident that the buck never stopped with you. Your bleeper goes off incessantly and you feel as though you have the weight of the world on your shoulders. You don't stop for coffee. You rush through your lunch, anxious to return to your ward so that you can finish on time. Five o'clock comes and goes and you are no nearer to going home. Of course, you could hand over these tasks to the on-call team, but you want to look after your own patients; you don't want to palm them off onto anyone else. You find yourself leaving your ward at six or seven o'clock and, although you're tired, you feel satisfied that you've done the best for your patients. This pattern of work isn't sustainable, however. Man cannot live by warm-glow-in-the-belly alone. It doesn't take long to learn that one of the most important skills of a junior doctor is deciding what can be put off until tomorrow.

Dr Elisabeth Paul, *London*

Degrees of excess

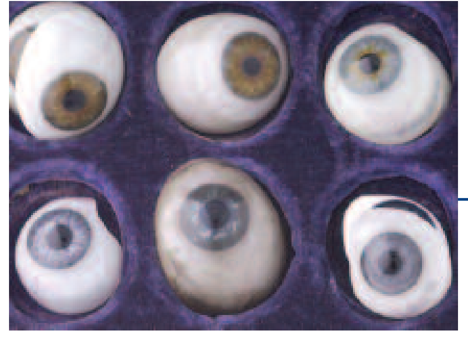
It was with interest that I read the article on the four medical schools now being able to award their own degrees. I wonder if this is wise given the current climate of Modernising Medical Careers (and the Medical Training Application Service) which are reducing the number of training posts and thus leading to a glut of doctors. If, as we are led to believe, it costs £250,000 to train a doctor, surely we should be reducing the number of those attaining medical degrees, not encouraging more. It would also avoid new graduates going through the pain and suffering of the current crop of junior doctors.

I know these schools already give degrees and the change just allows them to do it in their own name, but surely we should be reining this in not encouraging it?

Dr Peresh Gela, *Peterborough*

Editor's comment: The Government not the GMC took the decision to open the new medical schools; the GMC's role is to provide the necessary quality assurance.

Email your letters, marked 'For publication' and no more than 150 words in length, to **gmctoday@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.



The Wellcome Collection

GMC council member Joan Trowell went to look at the permanent collection of medical artefacts at the Welcome Collection.

Henry Wellcome was not just the founder of the eponymous pharmaceutical company, he was a Victorian whose interest in all things related to the body and health lead him to do what many wealthy Victorians loved best – collecting.

Over the course of his life he gathered over a million objects some 500 of which can be seen in the newly reopened permanent exhibition entitled *Medicine Man* at the Wellcome Trust's building close to the GMC's headquarters in London's Euston Road.

While his collection contains objects as diverse as ancient prosthetics and foetal models to Napoleon's toothbrush and George III's hair, it is arranged with both clarity and care in six themes including the beginning and end of life, self-administered treatments and the many ways the sick have sought help whether from doctors or deities.

In addition to the original collection, there are contemporary displays: at present entitled *Medicine Now*, which imaginatively illustrates the human body and obesity a modern disease, malaria a longstanding cause of mortality and morbidity for which a vaccine may well become available and the human genome and the contemporary controversy that surrounds genetic engineering. Many exhibits are interactive and conclude with an invitation to design a postcard sized contribution to build into a wall - adults and young people alike have done just that!

The Wellcome Trust's exhibitions are a fitting reminder of the unique legacy of a man who dedicated himself and his considerable fortune to medical progress while seeking to preserve its past.

Exhibition hours: *Tue, Wed, Fri, Sat 10-6, Thu 10-10, Sun 11-6, closed Mon. Free entry.*

Do you have something you'd like to review for other readers to share? If so email **gmctoday@gmc-uk.org**

Dr to Dr

If you wish to advertise, email ***gmctoday@gmc-uk.org*** *with the details, submitted in the form of those on the page. Ads are free but must be no more than 35 words in length. For reasons of space, we cannot guarantee to publish any ads and do not hold over unused ones. Please do not email asking why an ad has not run – simply email it again for the next issue if you wish. The copy deadline for the November/December issue is 20 October*

HOLIDAY ACCOMMODATION

→ **Cape Town:** Self-catering guesthouse in leafy, old neighbourhood, cottage style furniture, privacy. 20 minutes from wine routes, Table Mountain, waterfront, beaches. Sleeps 2; email: ascriba@netactive.co.za

→ **Crinan, Scottish West Coast:** Stylish 3 bedroom cottage in stunning hill-top location with panoramic views to Jura, Scarba and Mull. Beautiful walks and cycling, beach/watersports nearby. Sleeps 6. From £450/week. Tel: 01546 830134; email: dalmorecottage@hotmail.com

→ **Cornwall: St Ives:** luxury house to rent in quiet backwater. Sleeps 7–8. Very spacious 4 bedrooms, 4 bathrooms, 3 sitting rooms. 5 mins walk to town and beach; email: sjc63@btinternet.com

→ **France: Alps.** Ski-in/ski-out, luxury self-catering chalet apartment to rent. Sleeps 10–12. Traditional village, 200kms piste, 40 mins Geneva. Flexible English-speaking childcare optional. Tel: 020 8293 5784; email: thetahsins@aol.com

→ **France: Haute Savoie:** Studio apartment in centre of Les Carroz, about 1 hour from Geneva airport. Sleeps 2 with comfort - equipped for 4. Central location in village with free ski-bus to slopes. Ski the whole Grande Massif; email: dingleylotus@doctors.org.uk

→ **France: Meribel:** 3 valley: Perfectly situated 1 double,1 twin ski apartment very close to centre and piste. Booking now for next season. Negotiable rates for *GMCtoday* readers. Tel: 01732 811099

→ **Germany: Herz National Park:** Family holiday home in sleepy village. Deep forests, clear lakes. Ideal for bathing, walking and cross-country skiing. 45 mins from Hannover. Sleeps 4, garden, sun terrace & BBQ. £200-250/week; email: e.reinhold@doctors.org.uk

→ **Italy: Sestriere** (TO): Flat. Sleeps 7. Central village. Panoramic view overlooking ski and golf course (the highest in Europe). Fully equipped. 1 twin, 1 double, living room, bathroom, kitchen. £600 pw; email: manuela.graziano@libero.it

→ **India: New Delhi:** Furnished, air-con, 42" LCD, 2 ensuite bedrooms luxury Flat in Cannaught Place. Walking distance to shops, bars, restaurants, hotels. Available Nov/Dec. £600/week; email: suresh2309@aol.com

→ **Menorca:** Four individually styled villas situated in the coastal resort of Cala'n Porter. Private heated swimming pool (10mx6m). 15 mins from Mahon airport. fully equipped, air-con. Visit www.menorca-villas.co.uk; Tel: 01236 830640; email: alan.sheena@btinternet.com.

→ **Florida: Orlando:** 10 min to Disney. 2 bed/ 2 bath ground floor condo in Bahama Bay Resort- winner of Virgin best hotel Bronze Award 2006. All mod cons. Pools with jacuzzis, secure kid's pool/play area. From £376 per week. www.holidaylettings.co.uk/rentals/davenport/22031. Tel: 01268 493266/07939 678545.

→ **Portugal: Algarve:** Quinta da Saudade, 2 bed villa, sleeps 4/5. Maid service, pools, tennis & riding. 5 mins to long sandy beach & golf. From £250 per week. Tel: 01263 821005 (evening); email: sampsonnorth@hotmail.com

→ **Portugal: Algarve:** Luxury villa in village near Castro Marim and Spanish border, in unspoilt region. Large pool, grounds in beautiful setting, 7kms from sea. Sleeps 8. Out of season £100 per person pw, minimum £250. Tel: 07989 302260; email: vallance@oldbell.wanadoo.co.uk

→ **Portugal: Algarve:** 40 minutes Faro Airport. Modern town house in exclusive development. Gardens, 2 en-suite bedrooms, large lounge, dining area and kitchen. Balcony with sea views. Communal swimming pool, sauna, gym and children's play area. Close to beautiful beaches/golf, sleeps 4. From £500-700 week depending on season. www.holidayalgarve.eclipse.co.uk; Tel: 0230812789; email; leathb@doctors.net.uk

→ **Portugal: Silver Coast:** 2 bedroom apartment with sea view within Praia D'El Rey Golf and Beach Resort, Obidos. Sleeps 4-6. 1st tee 5 mins walk. beach 10 mins walk. Introductory prices. www.holidaylettings.co.uk (Prop.No. 33862).

→ **Reading:** 3 bed ground flat next to Thames. Tastefully furnished. Small patios front/ back. Large open-plan lounge diner. Modern kitchen. Located secure, quiet block. Garage, and parking. 1.5 miles from Royal Berkshire Hospital. 0.5miles from station; email: mark@doctors.net.uk

→ **Spain: Costa del Sol:** 3 bedroom villa with private pool 3km from the whitewashed village of Cómpeta. Spectacular views in all directions, including a sea view to the south-west and mountains to the north. Sleeps 6-8. Tel: 01524 770461; email: rwilley@doctors.org.uk; http://web.onetel.com/~rwilley/Panorama/index.html

→ **Tobago:** Spacious 2 bedroom, 3 bathroom fully equipped, self catering condominium. Sleeps 6. On 18 hole championship golf course. Pool and sea views. 5 minutes walk to beach and Hilton Hotel. £100/night; email: frank823@tstt.net.tt

→ **Tuscany:** Restored Farmhouse, in hills/panoramic views. 3 double bedrooms, 2 bathrooms, mod kitchen, 12 m pool, easy access to Siena, Florence, Perugia, Assissi £850 per week Tel: 01892 891171; email: cecile.goorney1@btinternet.com

FOR SALE

→ **Greece:** Newly redecorated 1 bedroom flat for sale in central Greece, sleeps 3–4, fully furnished, large balcony, communal garden, 5 minutes walk from beach, restaurants, bars, supermarkets. Thermal SPA nearby. Tel: Cristina 07976 049310; email: cgolfom@hotmail.co.uk

→ **Illustrated London News:** Bound copy of Jan to Jun 1860 – many illustrations. £100 ono. Tel: 01276 29391.

→ **Up-market Exam couch:** Hydraulic variable height and pitch. In store and need the space. £250. + ECG machine hardly used. Cost £1,000, now £250 email: mpetri@doctors.org.uk. Tel: Michael 01929 450346/ 07971 295480 in Dorset.

→ **MRCS STEP Course:** 2001 edition. Unmarked £50. All folders included. None missing. Due to weight, please collect. May deliver if near enough. Ascot, Berkshire. Tel: 07990 530129; email: yeok@wyeth.com

→ **ECG machine:** 'antique' portable battery operated - Cambridge Transrite 4–2. £125 o.n.o. Proceedings for donation to charity. Middlesbrough. Tel: 01642 318551.

→ **Braun Thermoscan pro 3000**. new, still in packet. £15. + bp wrist monitor Braun 2590 precision Sensor pro new, still in the wrap, £25. Tel: 020 8993 2313/ 07985 634 896

MISC

→ **Christ's College Finchley:** Are you a former pupil of CCF now in medicine? If so, get details of the Finchleian Medical Club's annual dinner at The Athenaeum, London; email: darryl.tant@ntlworld.com

Issue 15 September/October 2007

Mental Capacity Act implementation – are you ready?

Some useful Web resources to ensure that you are prepared for the Act that comes into force in October

For a quick overview of the Act and its Code of Practice, there are a series of easy-to-read introductory booklets published by the Ministry of Justice at **www.justice.gov.uk/guidance/mental-capacity.htm.**

To help doctors and others who will have to work with the Code of Practice, the Department of Health (DH) and Welsh Assembly Government have published a set of training materials for primary care trusts (PCTs), acute hospitals and other health and social care settings at **www.dh.gov.uk/en/publicationsandstatistics/publications.**

The Department of Health in England has funded training schemes and local initiatives to raise awareness of the Act. In May 2007 it issued advice to PCTs in England about specific funds being made available to support local implementation. Regional Leads have been appointed, working within local social services boundaries, to provide a focal point for health and social care service providers and staff who need more help or want to learn from others' experience.
Visit **www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Socialcare.**

For Wales, the Welsh Assembly Government has funded statutory bodies to support local implementation of the Act. In summer 2006 specific funds for training and awareness raising were distributed to local health boards, NHS trusts and local authorities. This funding was supported by the publication of a best practice self-assessment tool as an aid for local implementation planning. Statutory bodies should have MCA leads in place to cascade training and awareness raising, internally and externally with partner organisations.

In November 2006, local health boards were advised about recurring funding to be made available to support implementation of the Act from 2007/08 onwards – this includes funding for the new Independent Mental Capacity Advocate (IMCA) service. Visit: **http://new.wales.gov.uk/topics/health/nhswales/healthservice/mental_health_services.**

Consultations lead to new guidance

Two major consultations which have looked into developing GMC guidance for doctors have drawn to a close.

The three-month consultation on new consent guidance ended on 20 August 2007. Council member, Dr Edwin Borman, chairman of the consent review Working Group, said: *'We are grateful to the individuals, professional, regulatory and governmental bodies, and patient groups who submitted comments on the draft guidance, and to everyone who participated in the theatre workshops or attended one of the round table meetings held across the UK. Their views will inform the content of the guidance and help us to ensure that it is clear, realistic, useful and practical.'*

From July to September 2007 the GMC also held a public consultation on new guidance relating to personal beliefs and professional practice. This guidance is to expand on the principles in *Good Medical Practice* that deal with doctors' obligation to provide equitable access to care for all patients and with doctors' conscientious objections to particular forms of treatment.

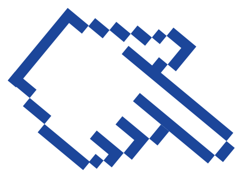
The consent and personal beliefs guidance will be published in early 2008.

New disability guidance

Guidance on disability equality is now available as a supplement to the GMC's core guidance on good medical practice.

The Standards and Ethics team at the GMC have been working on a number of projects to implement the fourth edition of their core guidance for doctors, *Good Medical Practice* (GMP), bringing the guidance to life for doctors and patients alike.

As previously reported, the GMC has been working with the Disability Rights Commission (DRC) to produce a supplement to GMP designed to draw out specific implications for disability equality. The finalised document is now available on the DRC's website **www.drc.org.uk** and the online version of GMP **www.gmc-uk.org/guidance/good_medical_practice** links directly from each relevant paragraph, giving examples of how the principles might apply in practice to disabled people. The DRC commented that: *'A high proportion of service users and their families are disabled people so this document is key to aiding doctors to understand how they can improve service delivery to this group of people.'*



GMP goes interactive

Work is also underway on a web-based interactive version of the GMC's key guidance publication *Good Medical Practice*. The scenario-based package is scheduled for launch later this year, and aims to demonstrate how complex the apparently simple ethical principles can be when taken out of the abstract. Look out in future issues of *GMCtoday* for further details.

Retired doctor should not have worked while suspended

A retired GP's name was erased from the medical register after a Fitness to Practise Panel found she had worked knowing that her name had been removed from a medical performers list (the List) and whilst her registration was suspended. The doctor also provided false information to a GMC panel and her conduct towards a patient was found to have been inappropriate and not in the best interest of the patient.

Until her retirement the doctor worked in single-handed practice. She was consulted by a patient who was six months pregnant and complaining of pain on her right side. The doctor failed to make an adequate assessment of the patient's condition: she did not take an adequate history; did not perform any, or any adequate, examination of her patient and did not perform a urine test. The doctor diagnosed the patient as suffering from muscle pain. She failed to diagnose that the patient was suffering from a urinary tract infection and failed to make an adequate record of the consultation.

The doctor was subsequently consulted by the same patient suffering from dizziness and 'seeing flashing lights'. During that consultation the doctor was impolite and inconsiderate towards her patient. She did not take a blood pressure reading nor did she check her urine for protein and therefore failed to make an adequate assessment of the patient's condition.

Good Medical Practice (May 2001) states that good clinical care must include making *'an adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination'*. It also states that doctors must *'be competent when making diagnoses and when giving or arranging treatment'* and that doctors must *'keep clear, accurate legible and contemporaneous patient records which report the relevant clinical findings, the decision made, and the information given to patients and any drugs or other treatment prescribed'.* The Panel found that the doctor's conduct fell below the standard expected of a registered medical practitioner and that her record of the consultations did not meet the required standard.

The doctor retired from practice as a single-handed general practitioner and her General Medical Services contract was terminated. She ceased to be included on the List but failed to inform a GP co-operative, with which she was registered as a duty doctor, of this fact. Despite the removal of her name from the List, the doctor worked for the co-operative on 17 occasions when she knew, or ought to have known, she was required to be a member of the List and a fully registered medical practitioner.

When her case was considered by the GMC's Interim Orders Panel (IOP) the doctor claimed that she had not practised since she retired. The IOP made an order suspending her registration whilst investigations were in progress. The doctor continued working for the co-operative on seven further occasions.

By continuing to practise while she was not on the List and whilst her registration was suspended and, further, by providing false information to the IOP, the Fitness to Practise Panel found that the doctor's conduct was inappropriate, misleading, intended to mislead, dishonest and liable to bring the medical profession into disrepute.

The doctor benefited financially from her dishonest actions. She placed patients at risk by continuing to practise when she was no longer on the List and after her regulatory body had determined that it was necessary and appropriate for the protection of members of the public to make an interim order suspending her registration. The doctor's conduct demonstrated that she put her own interests before the interests of patients and showed a blatant disregard for her regulatory body.

In view of the doctor's repeated and flagrant breaches of the regulations relating to practise as a general practitioner, the fact that she continued practising after her registration had been suspended and because of the false and misleading information she provided, the Panel concluded that her conduct was fundamentally incompatible with continuing to be a registered medical practitioner.

GMCtoday

Your views matter!

If you wish to share your views about a particular issue, or offer feedback on any of the articles in *GMCtoday*, please email the Editor at: **gmctoday@gmc-uk.org**

Copy deadline for the November/December issue is 20 October.

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REGISTRATION ENQUIRIES AND CHANGES
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