THE MESSAGE FROM MERRISON

IT was just over two years ago that Sir Keith Joseph, then Secretary of State for the Social Services, appointed a Committee of Inquiry into the Regulation of the Medical Profession[1] in response to a profound loss of confidence by many doctors in the General Medical Council. The Committee, in addition to a lay chairman, Dr A. W. Merrison, comprised seven lay people and seven doctors. There were two family doctors, both of whom were Fellows of the Royal College of General Practitioners.

The terms of reference were: " To consider what changes need to be made in the existing provisions for the regulation of the medical profession; what functions should be assigned to the body charged with the responsibility for its regulation; and how that body should be constituted to enable it to discharge its functions most effectively; and to make recommendations ".

The Committee has recommended an independent General Medical Council with a predominantly professional membership. Professional members, elected by the single, transferable-vote system, would exceed members appointed by the main educational bodies by ten.

The structure is interesting. There would be a large General Council, responsible for policy, with an elected chairman. This would be underpinned by several committees reflecting the main functions, with a small, elected executive chaired by the President. The whole organisation would be known as the GMC. The philosophy behind this structure is clearly explained: " The GMC should be constructed so that its considerable powers and duties do not pass to a very few members, still less to officials.... it must be responsive to the needs and wishes of the public and profession ". In other words we are being told: here is the governing body of your profession, with extensive powers; you elect it, but be clear that if anything goes seriously wrong you will have only yourselves to blame. Fair enough!

This democratic constitution is crucially important when the main functions of the Council are considered.

Medical education

Medical education is singled out as the most important function of the new General Medical Council and it is these recommendations which are of greatest interest to general practitioners. What is proposed is a three-tier system of education for every doctor in future. This will consist of undergraduate training, a new period called graduate clinical training, and specialist training. These three stages would be defined in the system of registration, co-ordinated and controlled by the GMC and regarded functionally as a continuum.

There are no radically new suggestions for the undergraduate period, but fundamental changes are proposed immediately after qualification. What the Committee has suggested is that the old pre-registration year and the period of general professional training proposed by the Royal Commission on Medical Education[2] should together be replaced by a new stage designed to make a generally-trained clinician of the medical graduate. Particular emphasis is placed on the many facets of the consultation.

The Merrison Committee makes no bones about the fact that it expects the universities, who would supervise the period, to set clear aims and objectives, and see that young doctors are helped to learn by teachers who know what they are doing. Here is a tremendous opportunity for general practice. Teaching practices, provided they achieved high standards, could have a major role for the first time in the training of *all* doctors.

The College welcomes the proposals for specialist training, because its evidence has been largely accepted. General practice would be recognised as a specialty, doctors entering as principals would be placed on the suggested indicative specialist register, and " the standards of general practice ought to be maintained in the same manner and to the same degree as other specialties ".

The Committee is also quite explicit about the general criteria for the admission of all doctors to the specialist register: " . . . every applicant . . . will have to be individually assessed—it is an integral part of the educational process . . . and methods used such as examination, continuous assessment, or a combination of both will have to be settled for each specialty . . ." The recommendation is bound to be controversial for general practitioners but, as Donald Irvine [2] argues in his Pickles lecture, which we publish today, general practice can no longer afford to put off a decision to introduce minimum standards for new entrants.

Registration

Three categories of registration are proposed. Restricted registration, granted on qualification and operating through graduate clinical training, would ensure that the newly qualified doctor would work under supervision. On the successful completion of this period, the doctor would become eligible for general registration. General registration would not differ in legal status from full registration today, and would operate through the next educational stage, specialist training. Indicative specialist registration would follow the satisfactory completion of specialist training; it would show the public—which essentially means employing authorities—which doctors had shown themselves competent to take the highest degree of clinical responsibility in their specialty.

Setting specialist standards—accreditation

The report suggests that the profession should build on the existing standard setting bodies, that is the Royal Colleges and the Joint Higher Training Committees, rather than try to design a completely new system for assessing and accrediting individuals. It recommends that the accreditation should rest in the hands of any body to which the GMC is willing to give that responsibility.

The implication for the Royal College of General Practitioners and the Postgraduate Training Committee for General Practice (the equivalent of a Joint Higher Training Committee) is critical. Will the College be recognised as the standard-setting body for general practice? In the absence of any other, it must have an overwhelming claim to provide this service.

The College's business is setting standards—the standards for general practice as a whole. And the argument that it is not representative of the profession can be countered powerfully by the fact that all the recognised accreditation bodies would be accountable to and supervised by the new GMC, which, as has been stressed, would be democratically representative of the whole profession.

The Committee has recommended against introducing a legal requirement for established doctors to be retested at intervals, because the methods for making valid assessments are not yet available. This said, it does emphasise the responsibility of the profession to maintain standards of competence in the public interest. This is an issue which the College as a whole is going to have to look at seriously.

Overseas doctors

On the evidence presented by the Royal College of Psychiatrists, the Royal College of General Practitioners and the Royal College of Nursing, the Committee concludes that some doctors from overseas do not reach a level of competence in basic medical education consistent with the minimum expected in British universities. It is clear about who is to blame. The report says " We believe that this unsatisfactory situation is principally to be attributed to a willingness on the part of the GMC to allow its duty as protector of medical standards to be compromised by the manpower requirements of the National Health Service ". Fortunately, the GMC is taking action; we can only agree with the comment of Merrison that the new arrangements should be implemented *resolutely*.

The overseas doctor illustrates a vital theme which runs throughout the report. Expressed simply, it is that bodies which set standards should work independently of government and the professional political organisations, which together have to make our Health Service work on a day-to-day basis.

Thus, when the inevitable compromises have to be made between the ideal and the possible, they are seen for what they are. In this way, problems are not blurred by lowering standards; instead new resources should be found to solve them.

The same theme of toughness and flexibility runs through the section on fitness to practice. At its heart, is the humane proposal that the registration system and mode of operation of the Council should be altered so that the sick doctor can be identified and helped rather than persecuted. The actual proposals are detailed and complex, but will repay close study by everyone who practises medicine.

Medicine in evolution

In this first major reappraisal of the regulation of our profession for over 100 years, it is hardly surprising that many questions remain unanswered, and that some new questions have been raised. It is right that this should be so. The renewal of our educational system and the ways by which we govern ourselves cannot be solved at a stroke; it is a continuing process in which we should all take part. This report has a ring of commonsense about it which ordinary doctors will appreciate though various self-professed experts and medical politicians may not.

We believe that it will stand with the Report of the Royal Commission on Medical Education [3] as another major signpost marking the progress of our profession. General practice is now given the opportunity to become an established discipline in medicine—provided the nettle of standards is firmly grasped.

REFERENCES

1. Committee of Inquiry into the Regulation of the Medical Profession (1975). Report. Cmnd. 6018. London: H.M.S.O.
2. Royal Commission on Medical Education (1968). Report. Cmnd. 3569. London: H.M.S.O.
3. Irvine, D. H. (1975). *Journal of the Royal College of General Practitioners*, **25**, 399–407.