Rationale behind the General Medical Council's proposed new procedure for the assessment of doctors' performance

AT its meeting in November 1992, the council of the General Medical Council formally decided to seek an amendment to the medical act 1983 to widen the GMC's powers to allow it to investigate cases of poor professional performance of doctors. Arguably, this would represent the biggest change in the way the medical profession is regulated since the GMC came into existence in 1858. The GMC council's decision in November followed a period of formal consultation on its proposals.

Some will wonder why the GMC needs more powers, and why existing GMC and National Health Service complaints procedures are not adequate to deal with the problem of the doctor who performs poorly. Furthermore, it might be argued that the introduction of medical audit would obviate the need for such procedures. It may therefore help to know how the GMC has arrived at these proposals.

The medical profession enjoys the privilege of self regulation, and it is primarily the function of the GMC to perform this task. Under the medical act the GMC keeps registers of those who hold recognized medical qualifications, it oversees the standard of medical education in the United Kingdom, advises the profession on standards of professional conduct and medical ethics, and takes action where doctors' health or conduct call into question their fitness to practise. However, the GMC has become increasingly aware that there is a considerable gap in its present powers: at present it has no powers to conduct investigations into the day-to-day standard of professional performance of individual doctors, even though there may be evidence that a doctor's performance is seriously deficient and is placing patients at risk. Performance in this context means the standard of professional knowledge and skills which the doctor usually displays, and his or her professional attitudes. The existing procedures of the GMC concerning conduct or health are not sufficiently flexible to allow the GMC to investigate such matters.

In many cases where a doctor's performance is less than satisfactory, complaints against the doctor arise, which are investigated locally by the relevant hospital authority or medical service committee, or are occasionally referred to the GMC. However, none of these procedures is designed to review the doctor's general day-to-day standard of performance, nor is there any mechanism for ensuring that a doctor seeks retraining in a case where his or her performance is seen to be manifestly deficient, or for reassessing the doctor's performance at a later date, to measure any improvement. Furthermore, the various NHS complaints, disciplinary and audit procedures are not sufficiently comprehensive to deal with all problems of poor performance, and in addition there are many doctors who practise outside the NHS, or whose practice within the NHS is limited to short term locum appointments.

It is this major lacuna in the medical profession's procedures for self regulation which the GMC is seeking to fill with its proposed new 'performance' procedure. It is important to stress that this is not an extension of its existing conduct procedures, but is an entirely different procedure, designed to deal with a different problem.

The profession as a whole has become increasingly conscious in recent years of the problem of the doctor whose standard of performance is unacceptably poor.[1,2] This is one of the reasons behind the growth of medical audit and the proposals which are emerging from certain quarters that reaccreditation should be introduced for doctors engaged in specialist practice.[3] In some cases of poor performance it may be that the doctor's professional knowledge and skills have never been of a high standard; in other cases the doctor may have allowed his or her previously high standards to slip, perhaps through a failure to keep up-to-date with developments in medical knowledge and techniques. As chairman of the GMC's professional conduct committee, I frequently come across cases where it is clear that doctors are consistently failing to keep adequate clinical records, or are regularly prescribing inappropriately, or do not know how to take a proper systematic history from a patient, or how to conduct an effective clinical examination of a patient as the basis for a diagnosis.

The GMC is not proposing to undertake regular review of the competence and performance of every doctor on the medical register. The new procedure would be invoked only in response to complaints about a doctor or a referral from a health authority, where the evidence suggested that the doctor's standard of performance might be consistently deficient. Furthermore, the procedure would be invoked only in serious cases — the GMC would not attempt to investigate every incident of alleged rudeness or substandard practice. The aim of the procedure would not be to punish the doctor for his or her failures, but to assess whether the doctor's performance was indeed seriously deficient, through peer assessment, and, if so, to try to improve that performance through counselling and retraining.

The principal stages of the procedure would be as follows: a complaint or referral would be considered by a medical member of the GMC. This would be the stage at which the decision would be taken (provisionally) as to whether the complaint raised issues of poor performance, misconduct, ill health, or a combination of these. It would be decided whether or not to institute the performance procedure. In the relatively few cases which would justify such action, this would take the form of local assessment by an independent team of three, comprising two doctors, with expertise in the relevant specialty and a third, non-medical assessor. If the team found that there were appreciable deficiencies, they would make recommendations for counselling and remedial action, and for any restriction which in their opinion should apply to the doctor's practice in the meantime. Retraining would then be followed by reassessment and, if the result was satisfactory, the GMC would then take no further action.

There would be no risk to the doctor's registration, provided that he or she cooperated and responded to the counselling and retraining. However, to safeguard the interests of the public, there would be a new GMC professional performance committee with powers to restrict or suspend doctors' registration. This committee would consider only the cases of doctors who failed to cooperate with the procedures, or whose performance failed to improve with retraining. It would be hoped that few cases would have to be referred to the committee, and that most doctors would recognize that it was in their best interests to cooperate with the procedures, and would acknowledge and be ready to take action to remedy any shortcomings identified in their performance.

The proposals prepared by the GMC have been drawn up after considerable informal discussion with professional bodies, including, among other groups, the Royal College of General Practitioners and the General Medical Services Committee. All of the groups who have been consulted informally about this matter have recognized the need for a new GMC procedure of this

kind. During the preliminary discussions I have frequently been asked for reassurance that the anticipated costs of the new procedure will not place an unreasonable burden on the profession — preliminary estimates suggest that, in the early years, the introduction of the procedure is likely to add no more than between £5 and £10 to the annual retention fee.

I was encouraged by the wide support in principle which the proposals have received among both the professional and other organizations consulted. I believe that the proposals are seen as demonstrating the ability of the profession to continue to regulate itself effectively. The GMC will now begin work on developing the procedures in much more detail, and there will be further wide consultation on that detail before the procedures are finally implemented.

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Psychiatric morbidity in children and adolescents: a suitable cause for concern

THE scope of British health care practice, the structure of the health service and the roles of both primary and secondary health practitioners have changed dramatically, particularly in the last five years, and will continue to do so (NHS and community care act 1990).[1] Few would not applaud the move of specialized care closer to where people live and work, though many professionals have expressed concern about whether or not the mechanisms currently being employed to promote care in the community and, in particular, the new funding arrangements from April 1993, will prove equitable, effective and safe. The shift towards an increasing status for prevention and health promotion is clearly signalled by the new contract for general practitioners, the health service reforms and, most recently, by the white paper *The health of the nation.*[2] Inevitably, the boundaries between primary and secondary care are having to be redefined and new alliances forged.

It is against this background that I call for increased awareness among general practitioners of the emotional needs of children generally and for the improved recognition and treatment of those children suffering psychiatric disorders, in particular. There can be no doubt about the importance of the problem. The level of psychiatric morbidity in young people is high and the majority of those suffering remain unrecognized and untreated. In the 1990 Robina Addis memorial lecture Rutter summarized the situation when reviewing the prevalence of childhood psychiatric disorder, the evidence suggesting increasing rates and links with mental conditions in adult life.[3] He concluded by emphasizing the potential seriousness of psychiatric disorders in childhood.

As in other areas of practice, the general practitioner is expected to deal with a major proportion of psychiatric morbidity among children and adolescents, and yet the training that most medical graduates have received in child and adolescent psychiatry in the past has amounted to familiarization, at best, though this situation is now improving.[4] At the same time there is growing concern about the extent of many secondary level mental health services for children and adolescents.[4,5] The training of those professionals working in this field has developed rapidly, as has the quality of those recruited.[4] Rutter gives a clear picture of the enormous gains made in the understanding of child development and the nature of child psychiatric morbidity, and in the treatment of this morbidity in the last 50 years or so.[3] Nevertheless, specialist services have developed unevenly and were caught at a sensitive point in their evolution by greater economic austerity after the mid-1970s.[4] Many specialists have been, and are, concerned that the present reforms of the health service could exacerbate the vulnerability of mental health services for children and adolescents, if the market pressures brought to bear are not effectively managed.[5] On the other hand it is equally possible that, if the market is well managed, there might be new opportunities for further development.

Needs assessment and health gain assessment are now public health and health economic techniques, respectively, central in the new commissioning process, inherent in the strategic approach to determining the work of the health service in the United Kingdom which arises as an important component of its reform begun in 1990 (NHS and community care act 1990). General practitioners have an increased role in determining the pattern of services, whether or not they are fundholders, and so are faced with the task of formulating their opinions of the needs of their patients. A mental health needs assessment survey conducted in one district showed that families, general practitioners and specialists had differing perceptions of which children would benefit from referral, and also demonstrated a significant shortfall in specialist resources (Evans SC, Brown RMA, paper presented to a seminar on child and adolescent mental health services, Royal College of Physicians, London, March 1992).

While an increase in specialist resources is clearly necessary, it is unlikely that these resources will be dramatically increased in the 1990s. Nevertheless, it should be possible to influence changes in service delivery patterns and targets, and to encourage the practical developments in service style which are now required. Important initiatives are already under way. Action for Sick Children published *With health in mind* in 1992.[6] This contains three papers presenting models for the commissioning and provision of mental health services for children and the involvement of users in specifying and monitoring such services. While much of the document relates to specialist services, it also contains information which primary health care practitioners will find useful in defining the nature of childhood psychiatric disorder and the types of service which they might provide, purchase (if fundholders) or advise health authorities to purchase.[7] A helpful summary has been published as a briefing paper by the National Association of Health Authorities and Trusts.[8]

Rutter has drawn attention to the rapidly developing academic base of child psychiatry, and primary care research conducted by, or in association with, general practitioners is a vital component.[3] In this issue of the *Journal,* Bowman and Garralda draw attention to how common child psychiatric disorder is and the frequency with which its sufferers present with physical symptoms to general practitioners.[9] Their principal finding is that psychiatric disorder is much more common among frequent attenders than non-attenders at general practice surgeries. If this were to hold true in other areas of the UK then a substantial number of children suffering psychiatric disorder are already in contact with general practitioners and, appropriately, Bowman and Garralda recommend targeting this group. This demonstrates that general practitioners could make an impor-