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viewpoint

The General Medical Council: an inside view

THE General Medical Council (GMC) is in a unique position within a triangle. At its vertices are: a government, in whose name doctors are regulated, that often uses the GMC as a whipping boy; a general public that often perceives it as a 'doctor's club'; and a resentful profession that provides its funding but often believes it is in thrall to political correctness. Can the fact that all three seem dissatisfied mean that we are actually getting some things right?

Three issues currently engage the profession: Shipman, revalidation, and double jeopardy.

Harold Shipman was convicted of drug-related offences in the 1970s. There were no health procedures then, and the only options for the GMC were to allow continued unrestricted practice or to erase. Given positive medical reports, and support from his new employer, he was not struck off. Thereafter the GMC had no mechanism to maintain scrutiny of him.

Whatever view is taken of the GMC through the retrospectoscope, the Registrar of Deaths, the Greater Manchester Police, the Coroner, professional colleagues, and even local undertakers all had opportunities to challenge Shipman. Another fact to remember is that the GMC is now a vastly different body to that of the mid-seventies and has undergone far-reaching reforms to all aspects of its operation.

Revalidation, a new procedure that will ensure that every licensed doctor is up-to-date and fit to practise is another contentious issue. Revalidation and the licence to practise is not about identifying potential medical murderers, but is about ensuring that registration means more to patients than the fact that a doctor acquired a basic medical degree at the age of 24 and that nothing bad is known about him or her. Revalidation is criticised as being too 'doctor-friendly', as not being sufficiently rigorous, and as being soft and woolly. Some doctors, however, see it as an intrusive, unnecessary over-reaction to shocking but rare medical scandals, and see dangers that appraisals that were meant to be supportive, formative, and educative will end up as National Health Service performance management.

The answer is in the middle: appraisal should survive with its original educational intentions intact, but there also has to be a 'clinical governance sign-off' that there are no current concerns about a doctor's practice. Clinical governance mechanisms are currently still short of full development but these two systems, with differing methodologies and outputs, will eventually lead to better and safer practice. The uncertainties that remain over the implementation of revalidation result from their boldness. The comprehensiveness and scale of the arrangements that are to be introduced are unique and are being watched internationally. That there are some teething problems on the introduction of an entirely new concept of what being registered and licensed means is, to my mind, only to be expected and something that the profession will work through with its usual pragmatism.

Finally, double jeopardy. The Council for Healthcare Regulatory Excellence (CHRE) is an invention of government established last year for the regulation of all healthcare professionals, including the GMC and others. It is a young body, still refining its *modus operandi*, with which the GMC has a statutory duty to cooperate and to acknowledge. The CHRE's role includes oversight of decisions of GMC fitness-to-practise panels. Under section 29 of the relevant Act, CHRE can refer decisions to the High Court if they are deemed to be unduly lenient and referral is judged necessary for the protection of patients. CHRE and section 29 are facts of life; and neither the GMC nor the profession can ignore them.

GMC members, myself included, are now precluded from sitting on its adjudication panels in favour of trained associates appointed on merit. The GMC always aspired to secure the right of appeal against potentially wrong and unduly lenient decisions in the name of protecting the public through the probity of its register; the government refused to grant this power of appeal. If it is not to abrogate its public duty, therefore, it must be right that if the GMC identifies a decision that appears wrong in law or unduly lenient, it should bring this to the attention of CHRE. The perception of double jeopardy may have some foundation, but that is not of the GMC's making, it flows from the government's granting CHRE the power to appeal panel decisions. This power cannot be ignored by the GMC, who should always acting in the public interest while being fair to doctors.

The GMC is the crucible of our professionalism because its four functions of registration, standards, education, and fitness to practise offer more satisfaction than the alternative — regulation by a contract with an NHS ridden by political correctness and party affiliation.

When I represent the GMC abroad I am welcomed as someone who is an elected member of a body with worldwide respect; and yet at home it is one that is little credited with doing a difficult job well. I offer this necessarily short piece as an explanation as to why I never apologise for belonging to an organisation that I believe deserves more respect in its own bailiwick.

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