their much lower mortality, had been included, and all this data must be provided if the claims made are to be substantiated.

Except for one report of a controlled trial of aprotinin (Trasylol)[20] no drug or regimen of treatment has been shown to be of unequivocal value in the treatment of acute pancreatitis, and during the period of this survey no special treatments were given to the patients under review. Twenty-two patients did receive aprotinin in effective dosage but this was not until 1968 and 1969, after the "complete" years used for the detailed statistical analysis. It is therefore interesting that when the absolute mortality for a first attack of acute pancreatitis, which was found to be 9 per million population, was taken and expressed as a percentage of the total number of cases collected, the case mortality rate was still of the order of 17% during the years 1961–7 in the Bristol clinical area.

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Merrison Committee

Report of G.M.C. Inquiry

British Medical Journal, 1975, **2**, 183-188

Dr. A. W. Merrison, F.R.S.

The Report of the Committee of Inquiry into the Regulation of the Medical Profession (Cmnd 6018, price £1.75) was published on 16 April. The Committee, chaired by Dr. A. W. Merrison, was set up in 1972 by Sir Keith Joseph "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." Printed below are extracts from the report, together with the conclusions and recommendations of each of its sections.*

*Members were: Dr. A. W. Merrison, F.R.S. (vice-chancellor of Bristol University); Dr. J. R. Bennett (consultant physician, Hull Royal Infirmary); Mr. C. M. Clothier (recorder, Master of the Bench of the Inner Temple, Judge of Appeal, Isle of Man); Miss Margaret Drabble (writer); Miss Catherine M. Hall (general secretary, Royal College of Nursing); Mr. N. G. C. Hendry (consultant orthopaedic surgeon, Aberdeen Royal Infirmary); Dr. D. H. Irvine (general practitioner, Northumberland, honorary secretary of the Royal College of General Practitioners); Mr. Ian MacDonald (president of the Council of Industrial Tribunals, Scotland); Professor D. C. Marsh (professor of applied social science, University of Nottingham); Miss Audrey M. Prime (staff side secretary, General Whitley Council for the Health Services of Great Britain); Professor K. Rawnsley (professor of psychological medicine, Welsh National School of Medicine, dean of the Royal College of Psychiatrists); Professor G. A. Smart (director of the British Postgraduate Medical Federation); Mrs. Jean G. C. Turner (surgical registrar); Mrs. Mary Warnock (research fellow, Lady Margaret Hall, University of Oxford); Dr. W. B. Whowell (general practitioner, Leicestershire).

General Views of Committee

In its opening chapter the report sets out the general views of the committee, stating: "In developing our views on the regulation of the medical profession, we come to the conclusion that these powers could be exercised only by a regulatory body (and we retain for it the name 'General Medical Council') constituted in a way substantially different from the present G.M.C. Our proposals for education and the judging of a doctor's fitness to practise must be read with this always in mind. *When, therefore, we refer to the G.M.C. in the rest of this report we mean (unless the context is historical) the G.M.C. which we recommend to take the place of the present one.*

"We do not attempt, in the report which follows, to solve all the problems of regulating the medical profession. Our task has been primarily to recommend machinery for the solution of problems and in some areas to point the direction of possible solutions which the profession itself must work out. What we have suggested is a framework within which difficulties can be resolved and which, we hope, will satisfy the profession and the community it serves; and be sufficiently efficient and flexible to take account of rapid continuing progress in science and technology, the changing use of medical resources, and the movement in attitude and outlook of the profession and public alike."

CONCLUSIONS

"Medical registration provides a means of recognizing the competent practitioner.

"It is advantageous to the public to be able to recognize, and to a member of the medical profession to be regarded as, a competent medical practitioner.

"The medical register is used by the public at second hand.

"A medical register necessarily involves a registering body with considerable powers, particularly over the providers of medical education.

"The medical profession should be largely self-regulated and should be regulated by an independent body."

Medical Education

On medical education the report states: "The prime weakness of the present system of control of medical education is that control through the statutory registration system—largely unchanged since 1886—covers what are now little more than the academic preliminaries to the assumption of full responsibility.

"There are three stages in the making of a doctor. The first covers the period when he begins to learn the science and skills and to adopt the attitudes which will be the foundation of his practice of medicine; it ends formally at graduation. The second is when he will, as a graduate, begin to learn how to treat patients and acquire the general experience of medical practice which will be necessary to him whatever specialty he follows. This at present consists partly of the preregistration year, and partly of the period referred to as general professional training. The third stage is the specialist training which will equip the doctor to practise his chosen specialty independently.

"We share the view which has now become widely accepted that every doctor ought to have received specialist education and we believe that this requirement should be reflected in the statutory registration system.

"It is our view that to ensure the proper organization—and thus impact on doctors—of each of the stages to which we have referred they must all three be defined in the statutory registration system. The *first*, undergraduate, stage is already defined in the present statutory system. We do not suggest many changes in relation to this stage. Part of the *second* stage is defined in the present statutory system but the rest is not subject to control which will ensure that all doctors acquire the experience of medical practice which we believe necessary to the making of a doctor. Doctors entering general practice are not placed under any formal pressure to do more than complete the preregistration year. For hospital doctors the period after completion of the preregistration year has become more of an introduction to the specialist stage of education than a period of general experience to round off, in combination with the preregistration year, the undergraduate period. We recommend a new approach to this stage of medical education. The *third*, specialist, stage was not structured at all until the emergence a few years ago of the Joint Higher Training Committees. The schemes of accreditation they have developed have no legal standing, nor is accreditation obligatory for practice in a specialist capacity. We recommend the extension of a full system of control to this stage of medical education through the introduction of statutory specialist registration.

"The changes we recommend in the statutory registration system, and in particular its extension to cover specialist education, will give the new G.M.C. a regulating function over all stages of medical education. We welcome this because only by having one body overseeing all medical education will it be possible to achieve what we believe has become essential: the *co-ordination of all stages of medical education*. This seems to us the only way of making sure of the satisfactory supervision of each part."

CONCLUSIONS

"Medical registration recognizes a certain standard of medical education.

"Because medical registration recognizes a certain standard of education, the G.M.C., as the registration body, must necessarily have power over educational bodies to ensure the equivalence of the standards of education conferring the right to registration.

"The N.H.S. system of appointing hospital consultants may be regarded as a specialist registration system.

"The N.H.S. specialist registration system is weak from a practical standpoint, too flexible as regards standards, and is an obstacle to the co-ordination of the planning of all stages of medical education.

"In considering the control of medical education, a distinction should be made between the control of individuals, the control of standards, and the control of resources.

"The supervision of individuals to ensure that they have reached set standards should reflect the desirability of diversity of educational provision.

"The Postgraduate Councils and the Regional Postgraduate Committees associated with them are an excellent means of resolving problems involving the interaction of resources and standards; such means of resolution being particularly necessary in the postgraduate field.

"The preregistration year cannot be regarded as a satisfactory period of education to deal with the important task of making a clinician of the graduate; and its unsatisfactoriness owes much to grave organizational weaknesses apparent in the control of the year.

"The period of general professional training recommended by the Royal Commission on Medical Education does not offer a remedy for the present inadequacy of educational concentration on the task of making a graduate into a clinician.

"There are three recognizable stages of clinical responsibility, namely practice under supervision, independent practice, and practice carrying responsibility for the care of the patient at a high specialist level; and these stages correspond to the three stages of registration we propose.

"The contribution of the Joint Committees on Higher Training and the Postgraduate Training Committee for General Practice to the organization of specialist medical education is very important.

"The introduction of a specialist register will, in the long run, secure, through its recognitionary character, that a specialist education will be normally necessary for any doctor wishing to exercise the highest degree of clinical responsibility."

RECOMMENDATIONS

"A specialist education should be, in general, a pre-condition of the independent practice of medicine.

"The planning of all stages of medical education should be co-ordinated.

"The medical legislation should be amended to impose a duty on the G.M.C. to promote high standards of medical education.

"Successful completion of an undergraduate course in medicine should confer the right to 'restricted registration.'

"The G.M.C. should continue to have the power to refuse to accept that a primary qualification is adequate for the purposes of registration; and should continue to have powers to visit and inspect medical examinations and to visit medical schools.

"The G.M.C. should develop further its informal methods of controlling undergraduate medical education, particularly by involving external examiners.

"The G.M.C. and the University Grants Committee should develop machinery to exchange information.

"The important task of making a clinician of a graduate requires the introduction of what we refer to as 'graduate clinical training.'

"Control of the standards of individuals undergoing graduate clinical training should rest with university medical schools.

"The universities will require more tutorial resources to discharge the responsibility we propose for them in relation to graduate clinical training.

"Overall control of the standards of graduate clinical training should rest with the G.M.C. and in particular, the G.M.C. should be empowered to refuse to accept medical schools' certificates of completion of graduate clinical training.

"The G.M.C. should be provided with reserve inspectorial powers in relation to graduate clinical training.

"The G.M.C. should develop informal methods of controlling graduate clinical training.

"The length of graduate clinical training should be a matter for specification in regulations made by the G.M.C. after wide consultation.

"Successful completion of graduate clinical training should confer the right to 'general registration.'

"General, or family, practice should be recognized as a specialty just like other areas of medical practice.

"Control of the standards of specialist education should rest with the G.M.C. by its maintenance of a specialist register.

"The reorganization of specialist medical education should be founded on the work of the Royal Colleges and Joint Committees on Higher Training.

"Control of the standards of individuals undergoing specialist education should rest in the hands of any body given that responsibility by the G.M.C.

"Detailed arrangements for the control of standards of specialist education by the G.M.C. should be worked out in the give and take of wide consultation.

"An inescapable consequence of the introduction of specialist registration is that the G.M.C., as the registration body, should have the power to determine whether any body's accreditation should confer the right to specialist registration.

"The G.M.C. should be empowered to send for those papers of accrediting bodies relevant to accreditation as a specialist.

"The G.M.C. should develop informal methods of controlling specialist education—for example, in the fields of the interchangeability of specialist experience, the relative complexity of specialties, the assessment of individuals, and the efficient use of the skills of women doctors through part-time specialist training.

"The possibility of an appeal right to the G.M.C. from the decision of an accrediting body, particularly on questions of the relevance of experience, should be considered.

"A specialist register should be instituted.

"The specialist register should be indicative in character.

"The status of specialist registration should be protected by the G.M.C.

"Continued registration should not depend on continued participation in education, but the G.M.C. should encourage the development of continued participation in education.

"The status and expectations of existing doctors should be taken very fully into account.

"Simplification of that part of the medical legislation dealing with education is highly desirable."

Overseas Doctors

Having reviewed evidence from the Department of Health and other sources such as examination results, the report states: "We believe that the inescapable conclusion to be drawn from the evidence we have received is that there are substantial numbers of overseas doctors whose skill and the care they offer to patients fall below that generally acceptable in this country, and it is at least possible that there are some who should not have been registered. Although these remarks must be read in the light of what we have said about . . . competence, we nevertheless believe that an overseas doctor may be allowed to practise in this country with a knowledge of medicine less than the minimum that would be required of his counterpart educated in the British Isles.

"Apart from this generally lower level of professional knowledge and skill, the evidence shows a second, although sometimes overlapping, difficulty. Much of the evidence reflects not upon the overseas doctor's professional knowledge and skill but on his understanding of patients and grasp of the language, attitudes, values and conventions of the community in which he practises. Even where an overseas doctor is fully knowledgeable and articulate in the professional field, his difficulty in communicating with patients in non-medical terms may constitute a major barrier to his integration into medical practice in this country. It would be surprising if doctors from overseas did not lack knowledge of the operation of the N.H.S., did not find difficulty in understanding the significance of the euphemisms and colloquialisms which for many patients are their most accurate means of expression, and even more surprising if they could easily come to grips with the variety of dialects they may encounter. This will particularly be the case where the graduate comes from a country where English is not spoken or where the use of English as a teaching language is being discontinued.

"We have pointed out that the Health Department's evidence differs little, if at all, from an assertion that the N.H.S. should set its own standards for overseas doctors. We understand that lying behind the Health Department's argument is the view that this is a practical position to take up: it allows for the possibility that in the United Kingdom the educational standards are, and should be, as high as, or higher than anywhere in the world, but that, provided an overseas doctor is competent, at a reasonable and appropriate standard for a junior hospital post, he should be allowed in by the G.M.C. even though it may be uncertain whether his country's educational standards are as high as ours. To insist, the argument continues, in the foreseeable future, on a United Kingdom standard, would require the expansion of medical schools in this country much faster than planned, and to an eventual size larger than planned. Such an argument is in our view unsound. It must carry the corollary that doctors in the British Isles are trained to an unnecessarily high standard. As a Committee we do not accept that doctors in the British Isles are trained to an unnecessarily high standard —and we doubt whether the assertion of the contrary by the Health Department would be accepted to be a disinterested comment. It is not for us to judge the ethics of a service which relies on a substantial supply of doctors from countries which are themselves seriously short of medical services.

"The harmonization of the specialist standards of this country with those of the Community is potentially awkward. We understand that the Directives prescribe a minimum period of training for each specialty, and that these minima are all exceeded by the current minimum periods required for specialist accreditation in this country. Evidently, therefore, doctors from this country *could* be put at a disadvantage compared with their Community colleagues. It is beyond the scope of our inquiry to make recommendations in this field, though the importance—if only to our specialist registration proposals—of a solution being found is clear. We believe that this must be a matter in which the G.M.C. must take a lead, and we have no doubt that this is one of the areas where the G.M.C. will have to use its informal powers, once it has an established standing in specialist education, to find a solution."

CONCLUSIONS

"The N.H.S. is very heavily dependent on overseas-trained doctors.

"The range of standards of overseas-trained doctors allowed to practise in this country projects substantially below that of home-trained doctors, and there are particular problems of integration for overseas doctors.

"Overseas-trained doctors have made an immense contribution to the development of the N.H.S. and in considering changes in the arrangements for admitting overseas-trained doctors to the *Medical Register*, the position of a group which has been encouraged by successive Governments to come to this country to help maintain the N.H.S. must be treated sensitively.

"No difficulty should arise over the application of fitness to practise controls to overseas-trained doctors."

RECOMMENDATIONS

"The G.M.C. should register only those overseas-educated doctors whose standard is up to the minimum required of a medical graduate in this country.

"It would be undesirable to introduce a qualifying examination at first degree level as a condition of admission of overseas-trained doctors.

"The G.M.C.'s proposals for new arrangements to control the admission of overseas-trained doctors should be implemented.

"Arrangements should be made for affording specialist registration to overseas doctors on the basis of education and experience obtained overseas.

"The Department of Health and Social Security should mount a study of training programmes for overseas doctors.

"The special arrangements which are being devised for the mutual recognition of medical qualification within the European Economic Community are to be welcomed."

Fitness to Practise

On fitness to practise the report states: "We recommend that the G.M.C. should be able to take action in relation to the registration of a doctor whose condition or conduct requires it in the interest of the public. By condition we mean mental or physical health including addiction to any drug. By conduct we mean the doctor's behaviour towards his patients, the general public, and towards his colleagues. In the interest of the public we include two closely interwoven strands: the particular need to protect the individual patient, and the general need to maintain the confidence of the public in their doctors.

"Our reference in the previous paragraph to 'the *registration* of a doctor' involves an important point concerning the general scope of the G.M.C.'s control of fitness to practise. It is possible to imagine a G.M.C. which, in some sense, might be a patients' 'ombudsman,' obliged to look into every aspect of doctors' professional dealings. We do not think this would be desirable, and believe that the G.M.C. should take action only in relation to matters which are sufficiently serious to raise the question of a doctor's continued right to practise. To do more would, in our view, disperse effort which should be centred on the crucial role of the G.M.C. in this field: looking at the doctor whose condition or conduct represents a general *public risk*. Furthermore, scrutiny by the G.M.C. of every aspect of doctors' professional dealings would entail considerable involvement in the day-to-day running of the N.H.S., which has its own arrangements for considering complaints about the standard of service provided by doctors employed within it. We think the G.M.C. should take care to explain why it cannot look into every action by a doctor brought to its notice, and that it must be concerned only with matters which question the continuation of the doctor's registration. A particular problem is the interaction of G.M.C. and N.H.S. procedures. We understand that persons who complain to the G.M.C. are frequently told to pursue their complaints with the competent N.H.S. authority, which they may find frustrating, particularly if the referral is inaccurate. We endorse, therefore, the following comment from the National Association for Mental Health (Mind) who told us, 'while it is proper that disciplinary action should be taken on different levels by different bodies, this situation is confusing for the public, and much greater initiative could be shown by [the G.M.C.] in making clear its disciplinary role *vis-à-vis* [N.H.S. authorities].'

"The G.M.C.'s actions towards those unfit to practise should be directed to the protection of the patient, not the punishment of the doctor. This should, in our view, be the case even where the question of his fitness to practise arises on account of professional misconduct. For a doctor to have his name erased from the register, and to be in effect deprived of his livelihood, is a very serious penalty, but that it is a penalty is a side effect rather than a purpose of regulation. It is important that members of the G.M.C., in any fitness to practise dealings, should constantly bear in mind that their duty is to protect the public. If punishment were to be the purpose of control, then members of the G.M.C. might be swayed to deprive a doctor of the right to practise on grounds other than a dispassionate assessment of the public interest. Only in the sense that punishment may be regarded as a sanction to back up the rules of society and deter others from breaking such rules do we regard it as appropriate to the regulation of fitness to practise. Certainly an atmosphere of punishment may, furthermore, discourage members of the profession or of the public from notifying the G.M.C. of matters which ought to be brought to its attention; especially, for example, of mental illness which also involved professional misconduct. We have tried to avoid words like 'discipline,' 'punishment,' and 'offence' in this chapter as a contribution towards ridding the G.M.C.'s control of fitness to practise of an aura of punishment. We recommend that the G.M.C. be scrupulous in the same manner."

CONCLUSIONS

"Schemes of re-licensure could not supplant fitness to practise controls.

"Effective control of doctors' fitness to practise depends primarily on the self respect of the medical profession.

"The position of persons reporting doctors to the G.M.C. in relation to actions at law is noted.

"The weight of evidence has shown broad acceptance of the existing G.M.C. controls of professional conduct.

"Supervision of doctors' professional conduct by the G.M.C. must be firmly related to doctors' professional function; the G.M.C. must be clear about its aims in supervising professional conduct and must communicate those aims effectively; and the G.M.C.'s procedure for considering individual cases of misconduct must be effective, sensitive and widely acceptable."

RECOMMENDATIONS

"The G.M.C. should be able to take action in relation to the registration of a doctor whose condition or conduct requires it in the interest of the public.

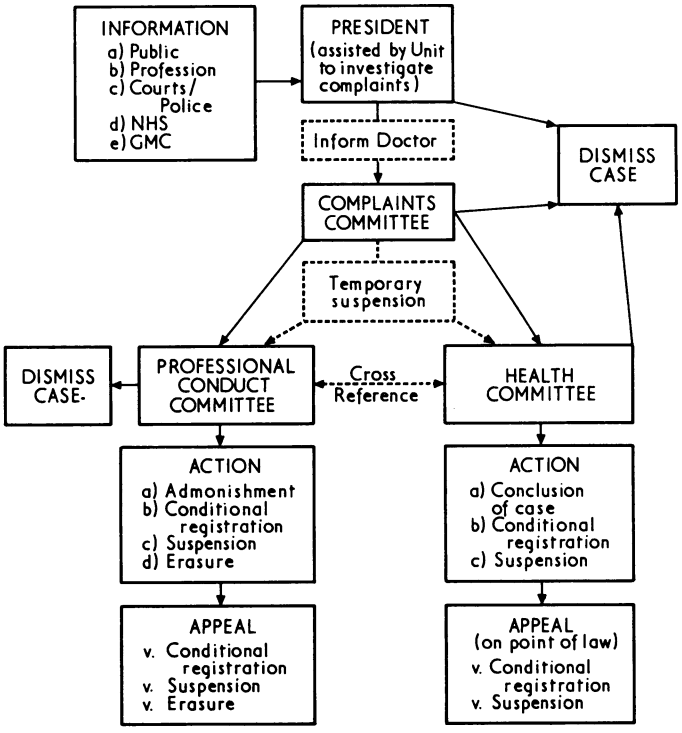

FIG. 1—Recommended Procedure for dealing with Fitness to Practise.

"The G.M.C. should take fitness to practise action only over matters sufficiently serious to raise a question of a doctor's continued right to practise; and should where necessary carefully explain this limitation to persons complaining to them about doctors.

"The G.M.C. should be governed, in procedures in this field, by the wish to determine the fitness to practise of a doctor and not to punish him.

"The institution of regular health tests for doctors with a view to securing more information about their fitness to practise is not desirable.

"The imposition of statutory duties to report doctors' unfitness to practise is not desirable.

"There should be discussion between the G.M.C., the Health Departments, and representatives of the profession on the future provision of information from the N.H.S. to the G.M.C.

"The G.M.C. should be prepared to play an active role in obtaining information relevant to doctors' professional conduct, and should be provided with the means to mount its own investigations of doctors' conduct.

"The present practice of the G.M.C. of allowing, very rarely, the maintenance of a complainant's anonymity should continue.

"The medical legislation should continue to include a duty on the G.M.C. to consider criminal convictions of doctors.

"The test of professional conduct contained in the existing medical legislation should not be altered, and in particular a code of conduct is not recommended.

"The G.M.C. should issue fuller guidance on the nature of professional misconduct.

"The G.M.C. ought not to commit itself to specific advice on what will constitute professional misconduct before the event.

"The initial sifting of information coming to the G.M.C. about doctors' professional conduct should be done by the President of the G.M.C. who should not chair the committee hearing allegations of serious professional misconduct.

"A Complaints Committee should be established, the principal function of which would be to consider whether prima facie evidence that a doctor was not fit to practise had been assembled.

"The practice of the G.M.C. in sending warning letters to doctors should be discontinued.

"The introduction of a 'circumstantial letter,' specifying what professional misconduct is alleged against a doctor, is not desirable; but greater openness in the G.M.C.'s procedure for acquainting doctors with the evidence in the G.M.C.'s possession is.

"A Professional Conduct Committee should be established, the function of which would be to consider doctors' criminal convictions and allegations against doctors of serious professional misconduct.

"The introduction of a jury system for professional misconduct proceedings is not desirable.

"The formal character of the proceedings of the G.M.C.'s Disciplinary Committee should be maintained in relation to the proceedings of the Professional Conduct Committee.

"Decisions of the Professional Conduct Committee on individual cases should not require a two-thirds majority of the members of the Committee.

"The range of sanctions to be used by the G.M.C. against doctors who have been convicted of a criminal offence or found to have committed serious professional misconduct should be enlarged in comparison with those at present available but should continue to be related solely to the doctor's right to practise.

"The G.M.C. should have the power to order the immediate suspension of a doctor's right to practise in certain circumstances.

"The Professional Conduct Committee should not be required to accompany a decision in an individual case with a reasoned explanation of its judgment.

"There should be a right of appeal to the Judicial Committee of the Privy Council for a doctor against a decision of the Professional Conduct Committee affecting the terms on which he may practise.

"A right of appeal against G.M.C. decisions on misconduct should not be conferred on complainants.

"The existing arrangements governing restoration to the register subsequent to misconduct proceedings should continue in force with the changes necessary to take account of other alterations of practice.

"The publicity given to misconduct proceedings should be controlled by legislation.

"The G.M.C. should be empowered to control the right to practise of doctors whose mental or physical condition requires such control.

"The G.M.C. should not establish local machinery to deal with doctors unfit to practise through illness; the local machinery needed for such doctors should be developed from existing N.H.S. arrangements.

"A Health Committee should be established, the task of which would be to consider, under defined procedures, the registration of doctors unfit to practise through illness; in particular the Committee should have the power to suspend a doctor's registration or to impose conditional registration.

"A right of appeal, limited to points of law, to the Judicial Committee of the Privy Council, should be established against decisions of the Health Committee.

"Medical students' entry upon what is at present the pre-registration year should not be made conditional upon a certificate of fitness to practise; but the formal health procedures might be used in the rare cases where registration is sought by a student about whose fitness to practise there is some doubt.

"The N.H.S. should retain its present power to dispense with the services of doctors, but should aim, firstly, to restrict its control of doctors' fitness to practise to matters pertaining to the maintenance of an efficient service, and, secondly, to provide support for the sick doctor."

Other Functions of the G.M.C.

RECOMMENDATIONS

"The G.M.C. should be statutorily charged with the duty of promoting high standards of professional conduct.

"The provision making it an offence to pretend to be a registered medical practitioner should be amended to make it wider ranging and more effective, and responsibility for initiating prosecutions under the provision should be widely accepted by bodies within the medical profession.

"The G.M.C. should continue to maintain the *Medical Register*.

"The G.M.C. should enter into discussions with the Department of Health and Social Security and the British Medical Association about the possibility of rationalization of the keeping of various lists of doctors.

"The G.M.C. should mount a study of the scope for making the *Medical Register* more informative and useful.

"The G.M.C. should mount a study of the desirability of annually issued practice certificates.

"The G.M.C. should adopt a rather more flexible attitude over doctors' addresses.

"The legislation governing the keeping of the *Medical Register* should be thoroughly reviewed with a view to simplifying it greatly."

The Regulating Body

When considering the machinery needed to maintain and assert the standards of the medical profession, the report states: "We have remarked that the regulation of the medical profession may be regarded as reflecting a mutually advantageous contract between the public and the profession, and looked at from this point of view one could as well argue that the performance of the contract should be enforced by a regulating body of laymen as of doctors. It is the case that the medical profession has been

regulated by a predominantly professional body for well over a century, and evidently a lay regulating body would labour under a substantial disadvantage. It is the essence of a professional skill that it deals with matters unfamiliar to the layman, and it follows that only those in the profession are in a position to judge many of the matters of standards of professional competence and conduct which will be involved.

"We are in no doubt that the community will indeed be best served by a professional regulating body. At so many points, as we have remarked, it is on the self-respect of the medical profession that the public must rely for high standards of medicine. That is the essential argument for a predominantly professional regulating body and why we recommend a predominantly professional G.M.C. The ultimate safeguard of the public interest is in the power of Parliament. The new G.M.C. will be established by Parliament through legislation, and Parliament will be able to intervene if the contract to which we have referred is not operating in the general public interest."

CONCLUSIONS

"The structure of the G.M.C. should reflect its functions.

"Once and for all registration fees which, from 1858 to 1970, were the G.M.C.'s principal source of income are inimical to sound finance in the present conditions of monetary inflation.

"The G.M.C.'s financial affairs have not been mismanaged.

"The present surpluses of the G.M.C. are not unreasonable given the likely future calls on the G.M.C."

RECOMMENDATIONS

"The G.M.C. should be independent.

"The G.M.C. should be predominantly professional.

"It would be undesirable to set up one regulating body for medical education and another for other aspects of regulation.

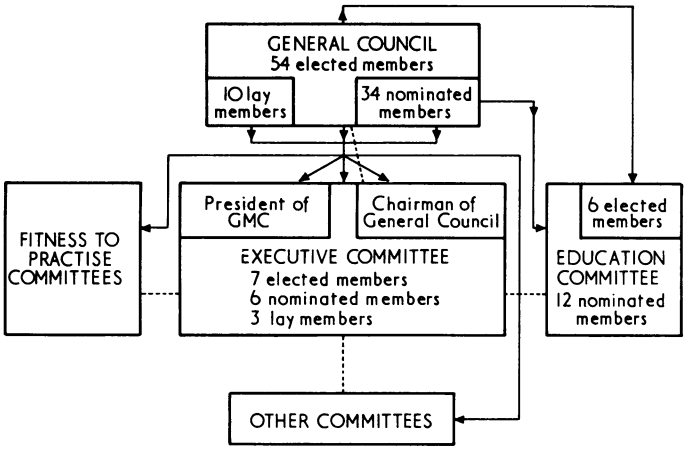

FIG. 2—Recommended Structure for the new G.M.C.

"A General Council should be set up, all members of which should be subject to certain conditions of tenure.

"The General Council should have members on it elected by the single transferable vote electoral system by registered medical practitioners resident in the United Kingdom. There should be 10 more elected members on the General Council than all other members. Special arrangements should be made to ensure the nomination of young doctors for election. A small amount of information about candidates should be circulated with voting papers. Casual vacancies should be filled by a reserve system.

"The General Council should have members on it nominated by the principal medical educational bodies; the right of nomination to be settled after wide consultation.

"The General Council should have 10 lay members on it.

"The Republic of Ireland should not send members to the General Council.

"An office of President of the G.M.C. should be established.

"An office of Chairman of the General Council should be established.

"An Executive Committee should be established.

"Fitness to practise committees should be established.

"An Education Committee should be established.

"The legislation dealing with the structure of the G.M.C. should be simple and reasonably flexible.

"The G.M.C. should be financed principally by the medical profession but with an unhypothecated Government contribution.

"The medical profession's financial support of the G.M.C. should be provided mainly by way of an annual fee for the retention of doctors' names on the *Medical Register*.

"The possibility of collecting the annual retention fee through the N.H.S. should be examined.

"Doctors' registration should continue to be withdrawn for failing to pay the annual retention fee."

Final Comments

The report concludes: "We have provided a report which we believe to be relevant and appropriate to all parts of the United Kingdom. We received no evidence from any of the constituent parts of the United Kingdom to the effect that the regulation of the medical profession ought to be other than on a United Kingdom basis. We have no doubt that this basis is the right one—or at least that it would be retrograde, especially bearing in mind developments in Europe, to have different regulatory arrangements for the different countries of the United Kingdom. To say this is not to say that we believe in uniformity of method throughout the United Kingdom, still less that everything should be ordered from London. We believe that though the goal must be the same throughout the country, the means to that goal may differ. We held one of our meetings in Edinburgh and all that was discussed was relevant to both sides of the border. We have already become aware of the vigour of the Postgraduate Council in Scotland and there is no doubt that the contribution of the Council must be taken into account in the regulation of medical education in Scotland. That is one example of the sort of flexibility which we believe to be important. Indeed administrative flexibility seems to us to be generally desirable: we can see no reason why, as another example, fitness to practise committees should not meet outside London when their business made that more convenient, though if it were desired to arrange meetings in Scotland, any implications arising from the separate Scottish legal system would need to be considered.

"We do not doubt that the responsible Ministers will wish to invite comments on our report very widely. It seems to us particularly important that the views and wishes of those in the constituent countries of the United Kingdom should be kept in mind, and we believe that a particular responsibility falls to the Secretaries of State for Scotland, for Wales, and for Northern Ireland to ensure that they are.

"We believe that the planning of the implementation of parts of our report dealing with functions should not wait upon the reformation of the structure of the G.M.C. Our report will take many years to implement and we think that the further delay on this account would be unacceptable. We hope we have suggested a system of regulation which will be appropriate at least for the rest of the century; that ought not to be the excuse for not getting on with the job."