1978 and all that

RICHARD SMITH

Since its inception in 1858 the General Medical Council has struggled with the difficult job of maintaining both public and professional interests, and many of the criticisms made of it now have been made since then. Its latest "revolution" grew out of protests made—mostly by doctors—during the late 1960s and early 1970s and culminated in the Medical Act 1978. Now a new head of steam is building up for further reform, with much of the pressure coming this time from parliament and the public. A brief historical sketch should make it easier to understand the current concerns.

In the beginning

Between 1840 and 1886 there were more than 50 legislative attempts at medical reform,[1-5] which attempted to balance the interests of three groups: the public in general and the state as an employer of doctors in particular; the royal colleges and other institutions offering qualifications; and general practitioners, particularly those in the provinces.

Members of the public wanted assurance that they were being treated by qualified and competent doctors, and the state wanted to know that it was employing such doctors—for instance, in work with the poor. Before 1858 some 19 bodies conferred professional titles, and the census in 1841 suggested that about 5000 of the 15 000 people then practising medicine were unqualified. All groups of doctors wanted qualifications defined so that "unqualified quacks" were excluded, but the royal colleges were anxious about losing power and prestige while general practitioners were worried that their inferiority would be perpetuated. These divisions continue—albeit in a less vitriolic form. One body of opinion wanted an essentially lay body that worked with government, but it made little progress.

The bill that finally reached the statute books was sponsored by W F Cowper, president of the board of health. In its early form the bill proposed removing the control of education from the royal colleges and transferring it to a General Council of Medical Education and Registration. The colleges opposed this, and they also opposed a proposal to create a single medical register. In a move reminiscent of another made over 100 years later the colleges succeeded in removing from the bill the council's power over education. Also removed was a proposal that doctors must be qualified in both medicine and surgery.

A newborn but castrated council

The bill that was finally passed had thus had its heart removed.[3] It created, in the words of one historian, "a barren neutrality"[1]: her analysis is that the public fared poorly because the failure to control education and compel dual qualification meant that it could not be sure that registered doctors were competent; the state fared poorly for the same reasons; and the general practitioners fared poorly because they had no representation on a council that included 17 corporation and university members and six crown nominees. Only the colleges and licensing bodies had done well by keeping their power.

The first register was published in July 1859 and contained almost 15 000 names. In 1866 the new council began its visitations of examinations and found alarming deficiencies, but it could do nothing. In 1869 the council recorded that the education of most of those to whom the main bulk of the population looked for medical assistance was so defective that the profession was in danger of being overrun with illiterate and incompetent men.

Naturally there was much unhappiness with the council. The newly formed Medical Teachers Association talked of the "utter corruption, incompetence, and abuses" of medical education. General practitioners were also discontented, and in 1870, 10 000 of them signed a petition calling for direct representation on the council. This petition had its modern equivalent almost a century later, as did the protest at the time that general practitioner representation would make the council too large to be efficient. Parliament was concerned as well with the deficiencies of the council, and between 1870 and 1881 more than 20 further bills were proposed. Eventually a royal commission set up in 1881 resulted in a new bill in 1886, which has been described by one historian as "the lowest common denominator of reform consistent with reversing the most blatant defects."[1] Direct representation was achieved with five practitioners being elected to the council by a postal vote of the whole profession; educational powers were strengthened a little; and, importantly, doctors were required to be qualified in medicine, surgery, and gynaecology.

Disciplinary procedures

In the early years of the GMC the disciplining of errant doctors took second place to the battles over representation and control of education. Although the 1858 act contained a section that ensured that the council was informed about doctors convicted by the courts of felonies or misdemeanours, the council heard few disciplinary cases before 1884. Most of the cases in the years thereafter concerned people pretending to be registered. In 1893 a penal cases committee was formed, and by 1915 most disciplinary cases concerned doctors employing unqualified assistants, and those canvassing, advertising, committing sexual misconduct, issuing false certificates, or performing abortions. Between 1919 and 1939 the committee heard only 311 cases, which came from two main sources: the courts, with many cases featuring drinking behaviour or accidents; and other official bodies, with complaints about false certificates.

The middle years

After the frenetic attempts at legislation of the nineteenth century it became quiet until the 1960s. The Medical Act 1950 increased the size of the council to 50 (44 doctors, 11 of whom were elected, three lay members, and three dentists), introduced the preregistration year, and gave the council the power to

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visit medical schools as well as investigate qualifying examinations. The Dentists Act 1956 set up the General Dental Council, splitting the dentists from the GMC, and also permitted modifications of the disciplinary procedures, which were further modified in an act of 1969. This act also allowed the GMC to charge an annual retention fee; previously it had supported itself with a once only registration fee.

Unrest in the 1960s

The introduction and subsequent increase in the annual retention fee proved to be the seed that crystallised widespread discontent among doctors about the GMC. This discontent led eventually to the Medical Act 1978, which followed the 1975 report of a committee of inquiry chaired by Sir Alec Merrison.[6] But Merrison and his committee had to consider many other issues apart from the retention fee. Margaret Stacey, professor of sociology in Warwick, who was on the GMC before and after the changes resulting from the 1978 act and has been conducting research into the council, has recently published an analysis of the changes brought about by Merrison.[7]

Inflation during the 'sixties together with an increased workload led the GMC into financial difficulties. Its financial affairs were independently examined, but eventually it had no choice but to introduce the annual retention fee in 1970. The fee more than doubled in 1972, and anger over the fee mixed with that over the unrepresentativeness of the GMC. General practitioners in particular thought that the council was far too dominated by elderly academics, who were out of touch with the realities of contemporary practice. The council then had 46 members: eight, including three lay members, nominated by the crown; 18 representing each of the medical schools; eight appointed by the royal colleges and one by the Society of Apothecaries of London; and 11 elected by a postal vote of all doctors registered with the council. "No taxation without representation" was the battle cry of the rebels, and between 2000 and 4000 doctors refused to pay the retention fee.

Thomas Wakley, first editor of the Lancet, who proposed that doctors should be regulated by a team of inspectors reporting to the Secretary of State for Health. Similar proposals have recently re-emerged as people grow more suspicious of self regulation

Another source of anxiety about the GMC was its inability to deal with sick doctors except through its disciplinary machinery. Nothing could be done about such doctors by the council until they got into trouble serious enough for somebody to make a complaint—and even then little could be done unless the doctor was found to have committed serious professional misconduct. The council itself had been worried about this and had instructed a special committee to investigate the problem in 1971.

A third problem concerned the registration of overseas doctors. Members of the public and hospital staff were worried not only that some overseas doctors spoke poor English but also that their basic medical education had not been adequate. A special committee set up by the GMC in 1971 to examine this issue concluded that overseas doctors should undergo a test of linguistic and medical competence before being offered a new form of registration—limited registration. Legislation would be needed to allow this to happen.

The fourth source of pressure to reform the GMC was the question of the council starting a specialist register, which arose when Britain joined the European Economic Community because the other countries in Europe have specialist registers. The government had proposed such a register in 1969, but the royal colleges, which accredit specialists, were opposed—their authority was threatened.

The coming of Merrison

In 1970 a special representative meeting of the BMA called for reform of the GMC. Sir George Godber, chief medical officer of England, responded by forming a working party of all the concerned groups. Reporting in 1971, it recommended that elected representatives should have a majority on the council. The GMC accepted this, but still the profession was not content—partly because the other questions had not been settled.

A joint working party of the BMA and the GMC was thus established under Sir Ronald Tunbridge, professor of medicine in Leeds, to look at the functions of the council. The GMC thought, however, that a broader governmental inquiry was necessary, and, although the council accepted the proposals of the Tunbridge working party, it voted at the same meeting to erase from the register those doctors who had not paid the retention fee.

The government at first resisted an inquiry, arguing that the problems of the GMC were a domestic dispute. But some members of parliament were worried that self regulation by doctors was breaking down and that the NHS was threatened. Eventually the government gave in, and in November 1972 announced an inquiry into the composition and functions of the GMC. Professor Stacey points out that the committee of inquiry was never asked to consider whether it was desirable that doctors should regulate themselves.[7] Sir Keith Joseph, who was then Secretary of State, said in the House of Commons in 1972: "It is not contemplated that the profession should be regulated otherwise than by a predominantly professional body."

Recommendations of Merrison

The Merrison committee, comprising seven doctors and seven lay members, recommended that the GMC should continue to be independent, predominantly professional, and financed principally by an annual

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George Eliot, whose book *Middlemarch* (published in serial form in 1871-2), provides the finest literary description of the state of medical practice before the Medical Act of 1858 established the forerunner of the General Medical Council.[8,9] Dr Lydgate, the main doctor in the book, may have been modelled on Thomas Clifford Allbutt, a member of the GMC from 1908 to 1918.

Eliot paints an entertaining picture of a variety of puffed up, incompetent doctors: Dr Spraque, whose "standing had been fixed for 30 years before by a treatise on meningitis of which at least one copy marked 'own' was bound in calf"; Dr Minchin, who diagnoses a case of cramp as a tumour needing an operation; and Mr Wrench, who diagnoses a case of typhoid as a "slight derangement" and prescribes dangerous drugs.

"For it must be remembered," says Eliot with irony, "that this was a dark period: and in spite of venerable colleges which used great efforts to secure purity of knowledge by making it scarce, and to exclude error by a rigid exclusiveness in relation to fees and appointments, it happened that very ignorant young gentlemen were promoted in town, and many more got a legal right to practise over large areas of the country. Also, the high standard held up to the public mind by the College of Physicians, which gave its peculiar sanction to the expensive and highly rarefied medical instruction obtained by graduates of Oxford and Cambridge, did not hinder quackery from having an excellent time of it; for since professional practice chiefly consisted in giving a great many drugs, the public inferred that it might be better off with more drugs still if they could only be got cheaply, and hence swallowed large cubic measures of physic prescribed by unscrupulous ignorance which had taken no degrees."

As Puschmann observed in 1891: "The English universities were really no more than public schools on an extended scale. Their function was not . . . to turn out doctors or men of science . . . but to provide state and society with cultured and independent gentlemen."[10]

But Lydgate was a man of science and was attracted to medicine by its scientific possibilities as well as by its potential for good. And "There was another attraction in this profession: it wanted reform, and gave a man an opportunity for some indignant resolve to reject its venal decorations and other humbug, and to be the possessor of genuine though undemanded qualifications."

Sadly, Lydgate, like some latter day reformers, came unstuck—and through a woman.

retention fee. The council should contain "members nominated by the principal medical educational bodies," 10 lay members, and "10 more elected members . . . than all other members." These members should be elected by a single transferable vote and "arrangements should be made to ensure the nomination of young doctors."

The committee also made many recommendations on function, including the concept that medical graduates should be given "restricted registration" until completion of graduate clinical training gave them "general registration." There should be an indicative specialist register, and the council should coordinate all stages of medical education. It should also be able to make recommendations to maintain and encourage high standards of clinical practice. The committee supported the GMC's proposals for testing the linguistic and clinical competence of overseas doctors and introducing a new category of "limited registration" for them. The idea of a health committee separate from the disciplinary committee was also supported.

Lord Richardson, who was at the time president of the GMC, welcomed the report "as an important contribution to the continuing evolution of the council and its work." In each of the chapters "which relate to the functions of the council," he said, "the committee's main recommendations are entirely consistent with the views expressed by the council."

By submitting high quality evidence and lobbying skilfully the GMC had mostly got what it wanted.[7] It also got what it wanted in the act itself, including an education committee that still contained a majority of unelected academics.

Enacting Merrison

The government accepted many of the recommendations of the Merrison report but—like its predecessors in the nineteenth century—had difficulty getting the profession's agreement on some matters, particularly postgraduate education. The government thus in 1977 moved a bill in the House of Lords that covered Merrison's recommendations on the composition of the council and its role with sick doctors but left out the recommendations on postgraduate training, the maintenance of standards, and the registration of overseas doctors. Lord Hunt of Fawley, a general practitioner, fought for the "half bill" to be turned into a "full bill" and largely succeeded. Thus the 1978 act enlarged the GMC and gave it new functions.

How much of a change?

Lord Richardson argued that the changes made in the Medical Act 1978 were "more extensive than those made by any previous Act." It is true that the council was twice its former size, and that it had a majority of elected members and mechanisms to deal with sick doctors and to test overseas doctors, but some of the people I spoke to—including some who had been on the council before and after the change—thought that the nature of the GMC had changed little. It was still a stuffy, reactive body dominated by elderly male academics. "The changes after Merrison were largely cosmetic," said Dr Michael O'Donnell, who has been on the council since 1971—making him the second longest serving member. As editor of *World Medicine* Dr O'Donnell played a prominent part in the campaign for change that led to the Merrison committee, but he is now unconvinced that much was achieved by the campaign.

Professor Stacey thought that from the public's point of view there was little useful change in the GMC.

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She said that the GMC "successfully kept the whole question of self regulation off the agenda." Although the absolute number of lay members was increased their proportion had decreased. "It could be argued," she wrote, "that the act, rather than being a radical reform, was a revision, a revision which made it possible for a medical elite, as little changed as possible, to remain in power and for professional self-regulation to continue unchallenged." For Stacey the reforms of 1978 reunited the profession—which has so often threatened to split into factions of academics, royal colleges, and general practitioners—but did little for the public interest.

Stacey thinks—with others—that self regulation looks anachronistic at the end of the twentieth century. "A task," she said, "which now faces the profession, and commentators upon it, is to think through what might be viable alternatives, more appropriate for modern health care practice. . . ."[7]

Conclusion

Originally it was primarily doctors who wanted a General Medical Council—in order to keep out the quacks. The difficulties in forming the council resulted from conflicts among the factions of the profession, and because of these conflicts the first council had few effective powers. It had to fight the royal colleges to gain power over undergraduate education, which remained inadequate long after the council was formed. Now the council is struggling to exert its influence over postgraduate and continuing education; still it is being resisted. Since the beginning of the council general practitioners have had to struggle to be represented, and although elected members are now in the majority, many think that they are excluded from real power.

The public interest, meanwhile, does not seem to have been the first concern of the council, although most members will insist that such is the council's first concern. In the early days priority was given to bringing together the various factions and little attention was paid to education and still less to discipline. Until very recently the council seemed to be more concerned with doctors bringing the profession into disrepute than with them failing in their clinical performance. The emphasis is beginning to change, but the question is whether the council can change fast enough to fend off demands for a body dominated by lay people or directly answerable to government.

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Lesson of the Week

Valproate and spina bifida

Pippa Oakeshott, Gillian M Hunt

Pregnant women taking valproate should be counselled about the risk of spina bifida and offered ultrasonography and amniocentesis

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In 1983 it was shown that when a pregnant woman takes the antiepileptic drug sodium valproate (Epilim) during the first trimester she has a 1-2% risk of having a child with spina bifida.[1] This risk becomes more evident with the decline in the overall prevalence of spina bifida.[2-4] It may be prevented by avoiding the drug during pregnancy or by informed counselling followed by antenatal screening for spina bifida with high resolution ultrasonography, amniocentesis, and abortion of affected fetuses.[5] In Britain few general practitioners seem to be aware of the risk of spina bifida and the special need for screening pregnant women taking valproate.

We report three cases of spina bifida in children born to women taking valproate as monotherapy who were unaware of the risk and were not offered prenatal diagnosis. All the children are currently receiving care.

Case reports

Case 1—A 27 year old woman had had her epilepsy well controlled with sodium valproate since the age of 22. In 1983 she had a miscarriage, but there were no details. In 1984, after a normal pregnancy, she gave birth at term to a 3020 g boy with open spina bifida at motor level L4. She had continued to take sodium valproate throughout her pregnancy. She had not been screened.

Case 2—In 1985 a 25 year old epileptic woman gave birth at term to a 3500 g girl with open spina bifida at motor level L5. (She had had a previous termination of pregnancy for social reasons.) She had taken sodium valproate 400 mg twice daily throughout her pregnancy. She was not screened until she was admitted with raised blood pressure at 34 weeks, when an ultrasound scan showed spina bifida.

Case 3—In 1986 a 25 year old epileptic woman gave birth at term to a 3200 g boy with closed spina bifida at motor level L3 and sacral agenesis. She had taken sodium valproate 200 mg three times a day throughout her pregnancy. She had previously had two normal children while taking this drug. She was not screened until she had vaginal bleeding at 30 weeks, when an ultrasound scan showed placenta praevia and spina bifida.

Discussion

The first important epidemiological evidence that valproate might cause spina bifida came in 1982 from Robert and Guibaud in the Rhône-Alpes region of France.[6] They found that of 72 children with neural tube defects, nine were born to epileptic mothers who had taken valproate during pregnancy. By including these data in a larger study the International Clearing House for Birth Defects Monitoring Systems decided "It is highly likely that valproate causes spina bifida in 1% of fetuses exposed to it in early pregnancy."[7]

Jeavons, in Birmingham, collected data on 196 pregnancies in which the mother had taken valproate;

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