There needs to be recognition that the clinical costs of research departments and hospitals represent more than the sum of individual patients entered into protocols—there has to be ongoing clinical activity to underpin the agreed research portfolio.

There are indications that Professor Michael Peckham is planning academic review for the post-graduate hospitals, and this could be a prelude to funding mechanisms along the lines outlined above. Such funding could and should be available for other institutions both within and outside London. If the mechanisms are fair and the funding is adequate to ensure survival of excellent research then the clinical research community may have cause to cheer. If, on the other hand, they result in lip service commitment to clinical research, but inadequate funding for its clinical consequences and a blind commitment to push research into the patient market, then the outlook is indeed bleak.

Conclusions

Clinical research is under threat internationally and nationally. The problem is urgent in London. It is vital that secure mechanisms be found for funding the patient costs of clinical research, before the service rationalisations cause destruction of London's clinical research programme. These mechanisms need to be robust, peer reviewed, and fully accountable. They should become a national framework, so that institutions in London compete on an equal basis with others across the country. In this way, clinical research throughout Britain could benefit and be strengthened by the current reorganisations.

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For public or profession?—the new GMC performance procedures

Margaret Stacey

Summary

The upheaval in the General Medical Council two decades ago came from doctors not the consumers the council was set up to protect. Since then there have been repeated calls for doctors to improve their self regulation by amending the disciplinary procedures. Private member's bills have failed and the GMC has now proposed performance procedures to deal with doctors who exhibit a "pattern of poor performance." After months of wide consultation in and outside the medical profession the GMC will decide next week whether to endorse the procedures, which unlike the conduct hearings will be inquiries by peers. Professor Margaret Stacey suggests that the procedures lack clarity, smacking of that "trust me" principle whose subtext is "but I'm not telling you what I'm up to."

When in the 1970s Merrison reviewed the regulation of the medical profession¹ there was little challenge to its sanctity. In the course of my research on the General Medical Council (GMC)² I interviewed a retired, senior civil servant who had had some responsibility in relation to the council. When I asked why there had been no discussion of the merits of professional self regulation his rather nonplussed reply was that in those days it would have been unthinkable. Rudolf Klein's voice³ calling for a council to oversee all the professions—which he felt got away with a good deal too much—had few echoes and nothing was done.

The upheaval in the GMC in the 1970s came not

from consumers but from medical practitioners who felt it was out of date, unrepresentative, and too expensive. The resultant Medical Act, 1978, produced a greatly enlarged council with, for the first time in its 120 years, a majority of elected members. However, no sooner was the reformed council getting into its stride than the radicalism of the new right released the iconoclasm of the 1980s, leaving no profession unscathed and giving new heart to many consumer movements, in health care as elsewhere.

Among challenges to the GMC came Nigel Spearing's 1983 bill proposing two levels of disciplinary charge, adding unacceptable professional conduct to serious professional misconduct. This flowed from the sad and well documented case of Alfie Winn, which I need not repeat here. Parliamentary interference in the GMC's affairs was unusual (and unwelcome), but this and other signals led the council to conclude that it must pay more attention to the area of competence.

The doctrine of clinical autonomy

The statutory duty of the GMC is to protect the public (unlike the BMA, whose duty is to protect the profession). As Merrison pointed out, the main way the council does this is by maintaining a "register of the competent."⁴ Yet, when I sat on the old discipline committee as a lay member in the second half of the 1970s, only the most severe cases of incompetence ever came to that committee, no doubt as a result of the doctrine of clinical autonomy. Apart from those convicted by the courts, doctors were charged with

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unfitness to practise, charges which then related mostly to the sick (those addicted to alcohol or drugs, for example), frauds and similar miscreants, those who had misused their professional power (to extort money or achieve sexual advantage, for example), and some cases arising from intraprofessional disputes. Happily, the 1978 act separated the "sick" from the "bad" so that the sick now are dealt with more humanely by the health procedures, leaving the conduct committee (as it now is) to deal with just that.

In the 1980s the number of cases involving incompetence, which got through the hoops of the preliminary screener, the preliminary proceedings committee, and on to the conduct committee, increased.¹ However, when found guilty, which the committee experienced as a difficult conclusion to reach, such respondents seemed to be leniently treated in comparison with those found guilty on other types of charge.² Yet what is more important to members of the public than that the doctors they consult should be competent to treat them and to know enough (and be humble enough) to refer them when necessary?

Still far to go

The GMC's new performance review procedures³ are an attempt to address this problem of competence—yet another disciplinary process for doctors to face. The council has argued that many complaints it receives are not appropriate for referral to the conduct committee—perhaps the failure is not severe enough or the case could not be proved. It argues that some of these complaints actually hint at a generally poor standard of professional performance which, with help, could perhaps be remedied, rather than a single disastrous episode. The proposal will come back to the council next week after a final six month period of consultation—the first one the public at large could take part in, although various patients' organisations have been informally consulted along with the medical bodies during the preceding 18 months before the plan came to the council meeting in May this year.

Not surprisingly the GMC has had to do a lot of hard talking to persuade the profession that yet more discipline is needed. The bottom line throughout has been, as Richard Smith reiterated last May, that if the profession does not do it someone else will and the great privilege of self regulation may be lost.⁴

In these circumstances medical practitioners may be surprised to learn that what they see as a great concession, not to say interference, is not viewed by all

lay people as totally satisfactory. Why should this be so? After all the GMC over the past decade has increased the number of lay members, introduced a layperson into the preliminary screening process, and included laypeople in the new proposals at the local as well as the national level.

Fundamentally the problem is that, as with so much self regulation, the proposals are tipped to the profession rather than the public. This can be seen in the criteria to be used to select cases for either performance review or conduct review (or neither, since in both cases the alleged shortcoming must be serious); the lack of symmetry in the treatment of respondent practitioners and complainants; the secrecy surrounding the proceedings; and, not least, the fact there are practitioners who are performing poorly but to whom no one draws the GMC's attention.

What criteria separate conduct from performance?

The consultative document offers no clear criteria by which screeners will distinguish cases of possible serious professional misconduct from those which suggest poor performance over time.⁵ The preface distinguishes between specific and closely defined allegations and those which are general. When the procedure is described in more detail (paragraph 6.1) the circular statement emerges that a "pattern of poor performance" is something which seems to the GMC screener "to be symptomatic of a pattern of seriously deficient daily practice."

Indeed, the difficulty of distinguishing between poor professional "performance" and "conduct" is stressed. Most letters are said to contain allegations about both poor performance and misconduct (7.1.4). Examples are given of letters and referrals which raise performance, rather than conduct or health issues (6.2): "cases where there are repeated complaints of a doctor's failure to carry out a proper medical examination of his or her patients, or cases where the GMC has received a number of independent reports that a doctor engaging in itinerant locum hospital practice has been regularly failing to provide an acceptable standard of medical care, or letters about doctors whose regular pattern of prescribing appears to be endangering patients."

Why do these not raise the possibility of serious professional conduct? Furthermore, ways of reviewing general performance may be needed when a doctor has been referred to the conduct committee.

Only suspected seriously poor performance will find its way into the procedures. These, the GMC says firmly, are not to be a way of introducing a second and lower standard of professional conduct such as Nigel Spearing calls for. Yet the performance procedure proposals do not provide for erasure; the most serious ultimate outcome for a doctor who does not respond to assessment and retraining is indefinite suspension by the proposed professional performance committee.

Conduct cases, as constituted at present, do not allow for an examination of a doctor's record over time at an early stage in the proceedings. The single episode on which a case of serious professional misconduct is based may be the tip of an iceberg of longstanding and serious deficiencies in practice. Hints of this sometimes emerge at the close of proceedings when reports on a doctor's past are revealed or when a doctor reappears having had another grave error reported. In the meantime the public has been put at risk.

Profession before public?

The procedures are lopsided: the sensitivities of practitioners under investigation are recognised and safeguards built in to meet these, but the sensitivities of

complainants receive less consideration. Five flow charts tell the respondent doctor exactly what may happen to him or her at all stages. No comparable flow chart shows where and when he or she comes in, although communicating with the complainant is mentioned in figure 1 and some reference is made in the text (7.5.2, 14.2.2). The need for sensitivity towards the respondent doctor in selecting the assessment team is recognised "and in certain cases sensitivity to the needs of the complainants will be necessary" (8.1.7). Why only in certain cases? Why not always?

The investigation is to be "professionally based, but with lay input." It will not be a confrontation as in conduct hearings (3.5.1). In conduct hearings the GMC prosecutes on behalf of the public. Performance procedures are to be different—inquiries by peers, more like the health procedures. On behalf of the public (and in consequence of the profession) the GMC will investigate possible failings in practice and help the doctor improve. In this case, the complainant is not an adversary any more than the GMC is. Patients' grievances are to be used for the general improvement of the profession. The satisfaction complainants will receive will be that "the doctor's standards are being improved, rather than that their individual complaints have been tested in a public hearing and either upheld or not" (4.11).

The GMC has recognised the need to include laypeople in the procedures and that medical treatment involves many aspects other than the technical. Yet the laypeople are not given equivalent status to that of the doctor. A lay screener will be involved in selecting cases after the medical screener has been through them. The assessment team will include laypeople but led by a medically qualified member.

Although complainants are patients with experience of what it is to be ill and receive treatment, they are not seen as competent people who could help in performance assessment. They have astute knowledge about a practitioner's performance. Other patients of the practitioner could, for example, give evidence about the typicality of the experiences complained about. What's more, some laypeople have a specialist knowledge of things that can go wrong in medical practice. I think of those who for many years have helped patients in making complaints or claims; their understanding of matters from a patient's point of view is unavailable to doctors (even though the doctors are, from time to time, patients). No reference is made to the possible use of such "specialist advisers" along with the medical specialist advisers.

Does professional self regulation work?

Questions of this sort undoubtedly expose problems associated with self regulation. The doctrine is that members of the public, not being peers, can participate only in very limited ways. Yet if patients were accepted as being of equal worth and as having competent things to say about their doctors' medical performance and their skilled spokespeople recognised, not only the appearance but the actuality of the GMC's performance as protector of the public would be greatly enhanced.

The GMC is not the apex of a general complaints procedure; its purpose is to regulate the profession on behalf of the public so that we may trust the doctors who treat us. Yet these proposals leave room for doubt about the GMC's good faith from the public point of view. We are told the new procedures will not provide a refuge for doctors who would otherwise face a charge of serious professional misconduct (3.1.1). Yet this conclusion is hard to escape given the lack of clear distinction between cases that will go down the performance or the conduct route—both defined as serious. The absence of clarity smacks of that "trust me" principle whose subtext is "but I'm not telling you what I'm up to."

I am still left wondering why the council does not simply inform the profession that a pattern of seriously poor performance amounts to serious professional misconduct—for surely it does. That might mean amending the existing conduct procedures. If necessary, why not? I wonder too why the GMC cannot accept two standards, serious professional misconduct and unacceptable professional conduct, as New Zealand does and as Spearing suggests.

The GMC makes much of the powers granted to it by parliament. Up to now its powers have for the most part been those which the profession has asked for. Public and parliament need assurance that any new powers it is granted will help it to work even better in the public interest than it has hitherto. The present proposals, although a most welcome attempt to get to the heart of a major problem, are not totally convincing.

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In many ways, but particularly in its hostility to state intervention, to the principle of compulsion, and to the medical profession, the antivaccination movement had much in common with the campaign against the Contagious Diseases Acts. There was also a similarity in the nature of the debate between the conflicting parties, for much of it turned on the interpretation of statistics, in the one case of venereal disease, in the other of mortality from smallpox. Did the statistical evidence prove that vaccination lowered the incidence of smallpox? The *Journal's* answer was unequivocal: "more lives are saved by vaccination," it asserted in 1886, "than by any other means which medical men possess for combating disease." But there was much to be said on both sides. Hart's pamphlet "The truth about vaccination" brought him personally into the debate.

In the 1870s antivaccinationists were mainly concerned with establishing the right of conscientious objection and with mitigating the penalties imposed upon defaulters. Many campaigners were out and out crackpots, but the argument that multiple penalties could severely and unfairly punish people such as Charles Nye, who, having seen two of his children die soon after vaccination refused to allow a third to be vaccinated, had

some validity. In 1880 the government, persuaded that real injustice was being done to genuine conscientious objectors, proposed to relax the full rigour of the law. Faced with the prospect of a bill to abolish multiple penalties, Hart argued that the "very large majority of defaulters are persons who are indolent and apathetic on the subject of vaccination" and attacked the government proposals as "legislation for the benefit of the few at the expense (the very terrible expense) of the many . . . [which would] virtually . . . condone the permanent violation of a most necessary and health-preserving law." The BMA's Parliamentary Bills Committee, with Hart at its helm and the *Journal* as its mouthpiece, coordinated opposition to the bill. The result was that the government abandoned its plans.

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