Profile of the GMC

The council's internal problems

Richard Smith

Although some members of the public are sufficiently unhappy with the General Medical Council to want to see it swept away, doctors who are unhappy with the organisation tend to be most dissatisfied with its internal workings and simply want gentle reform. They are unhappy with the size and cost of the council, its remoteness, unrepresentativeness, slowness, and backwardness, and the difficulty it has in taking a lead. There does not seem to be much love for the council among doctors. Many of its members whom I spoke to thought that this was inevitable but that the council might do better at being understood, appreciated, and used; that has been one of the aims of a group that has been looking at improving its internal workings.1 A related worry—and one that particularly concerns the staff—is that they are overworked and badly housed.

Size of the council

“The main problem with the GMC is that it is elephantine,” a former senior member of the staff told me. It grew considerably after the 1978 Medical Act—from 46 members to 97—and it is to be increased to 102. More lay members were needed because they are represented on more committees, and the number of elected members had to be increased to ensure their majority. The size of the council naturally carries economic implications (although the full council meets only twice a year), but a more important problem is that some of the members think that it results in poor debates and limits the power of the full council. Much of the work must necessarily be done elsewhere, in committee, and the full council is primarily concerned with talk and rubber stamping decisions made elsewhere.

Neither the past president, Sir John Walton, nor the current registrar accepted this point; something that worries them more is that the size of the council makes it difficult to ensure that all members are on at least one committee. This is important because much of the work is done by the committees. Almost all members are now on at least one committee, but some can make only a small contribution to the council’s work.

The size of the council has arisen from various competing pressures. All the university medical schools want to be represented, particularly because they see control of undergraduate medical education as the central function of the council. This means 21 members—one from each university medical school, including three from London. The Society of Apothecaries is represented because it grants a qualification, and the royal colleges and faculties are represented because of the council’s coordinating role in postgraduate education, giving a further 13 members. The Queen through the Privy Council nominates 13 members—11 lay members and two medical members, one of whom is the chief medical officer of England and the other is one of the other chief medical officers (they rotate). Then because of the principle established by the Merrison committee and enshrined in the medical act that the elected members must outnumber the total number of appointed and nominated members there must be at least 48 elected members—and to avoid the expense of byelections there are 54.

Although several members of the council have criticised its size, there is little debate about decreasing it—presumably because it is so difficult to take away from those represented. A former member of the staff suggested to me that the number of elected members should be reduced, but this is clearly politically impossible after the ructions of the 1960s and ’seventies. Nor would it be politic to reduce the number of lay members when an increasing number of the public seems to think that the GMC is not performing well in its primary responsibility to the public and should be a predominantly lay organisation. Some would like the two nominated medical members to be removed, but this would not seem wise when links between the council and the health departments are already fragile.

The only debatable option would hence be to reduce the number of representatives from medical schools, royal colleges and faculties, and the Society of Apothecaries. There seems no reason why they should not be grouped together, and a reduction in their numbers would permit a similar reduction in the elected members.

Unrepresentativeness of the council

Although over half of the council is elected, it does not reflect the composition of the profession. “It is still,” one member said to me, “terribly aged, and there are far too many academics.” The mean age of the medical members of the council is 57.5; the mode is 61, and only nine members are under 50. (These data are collated from the Medical Register and assume graduation at age 23.) The old and academics are over-represented whereas junior doctors, overseas doctors, and women doctors are underrepresented. Figure 1 compares the ages of the medical members of the GMC with those of doctors practising in the NHS. Only eight of the 86 medical members of the council are women, and only six members qualified overseas. The under-
representation of junior doctors and women doctors arises not only because they are unlikely to be deans of medical schools but also because it is harder for them to find the time to sit on the council and its committees. Those sitting on the professional conduct committee must, for instance, spend at least two weeks a year in London.

The Merrison committee was much concerned about the unrepresentativeness of the council, which was if anything worse before it reported than it is now, and explored various options for improvement. It rejected the proposal of reserved places for special groups on the grounds that it "may become a matter of controversy" and (a rare flash of humour) that "if, for example, a place were reserved for a representative of left handed general practitioners with red hair, that might keep out a very able doctor not falling within these criteria." It also rejected elections on a regional basis and opted for a single transferable vote electoral system. This is what the council now has, but the Merrison committee also wanted a mechanism to ensure that at least eight young doctors were nominated in each election. This has not happened. The Merrison committee did not define what it meant by young, but only two of those standing in England in the current election are under 35 whereas seven will if elected be over 65 by the time they take up their seats.

The 11 lay members are nominated by the Queen through the Privy Council on grounds that are not publicised. In the age old British tradition "the right sort of people" are discovered. Lay members do not know why they are picked and similarly do not know why they are or are not renominated. The problem for them is that they represent the public and yet are not elected by anybody. They float in a vacuum, picking up their views on what the public think from dinner parties in Oxford, Edinburgh, or wherever. They are generally middle class, white, middle aged, and well educated. Professor Margaret Stacey, professor of sociology in Warwick and a former lay member of the council, suggested to me that it might be possible to have at least some of the lay members elected—perhaps, for instance, as representatives of community health councils. She also thinks that a nurse should sit by right on the council as does a doctor on the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting.

Where does power lie?

In any organisation it may be difficult to work out where true power lies, and this is the case with the GMC. Although power should lie with the full council, this cannot be the case most of the time because the council meets only twice a year, is too large, and has too much to consider. Furthermore, many of its members are only partially aware of what is going on in many of the committees. The power of the subcommittees is limited by their individual mandates. As a discussion document on the future of the GMC produced by a group of elected members said: "The subcommittees often have no endpoint and no time limit. Some definite controls and checks should exist to ensure that [they] ... are necessary, effective, efficient, and economic...."

The same group observed that the executive committee, which advises the president, "is large... is not in a good position to act as a decisive 'executive committee'... and... is not in touch with the internal workings of the council." The group suggested that a kitchen cabinet be formed around the president, a suggestion taken up by the council's working party on the GMC in the 1990s which has just been accepted by the full council. The new president's advisory committee is to contain one elected, one appointed, and one lay member in addition to the president, the deputy president (if there is one), and the chairmen of the committees. It will meet regularly, and three members will constitute a quorum.

This committee may well come to wield considerable power, not least because it will be so closely associated with the president, who undoubtedly has considerable power. The president is elected for a maximum of seven years, and some of the past presidents have set as much of a personal stamp on the council as the present prime minister has set on the government. The respon-

Keeping the register

Ever since its inception the central job of the General Medical Council has been to keep the register of medical practitioners. Its other tasks—of guaranteeing the quality of those entered on to the list and removing those who do not reach the necessary standards because of poor conduct or health—flow naturally from this.

The GMC maintains two registers—one for doctors with full or provisional registration and another for those with limited registration. The registers contain names, addresses, qualifications, sex, and dates of full and provisional registration. The register of those provisionally or fully registered divides into four lists. The principal list contains 152 000 doctors, most of whom live in Britain. Many of these doctors are, however, retired; some live abroad but choose to remain on the principal list (paying the annual retention fee). Doctors may remain on the list but be exempted from payment of the retention fee because of age or premature poor health. Exemption because of age may be claimed by any doctor reaching 65, but exemption because of premature retirement on health grounds has to be approved by the registration committee.

The overseas list includes some 44 000 doctors who are fully or provisionally registered but who are living overseas. These doctors do not have to pay the retention fee but neither may they vote in the GMC elections. The visiting overseas doctors' list contains a handful of foreign doctors, (currently 13) who provide specialist services in Britain occasionally. Another list—the visiting European Community practitioners list—contains similar doctors from other countries in the European Community; currently there is nobody on the list, but it has, for instance, contained the name of a Danish orthopaedic surgeon who came occasionally to Britain to operate on dancers. The second main list is that of doctors with limited registration. It currently contains about 3500 doctors.

Eligibility for the main register is straightforward. British doctors need an approved qualification and for full registration a certificate to say that they have satisfactorily completed a preregistration year. Doctors from the European Community need a qualification and evidence of nationality and good standing within their country of origin. The requirements for limited registration have been discussed in a previous article (27 May, p 1441).

Roughly 25 staff are engaged in maintaining the register, which by law must be maintained in the form of a card index. The staff deal with over 1000 alterations to the register each week, and in the early weeks of August—when young doctors are being provisionally and fully registered—the number reaches almost 5000. The register is kept on computer as well as in a card index, and the day will surely come when the computer register will suffice. This will, however, require amending legislation as well as increased computer consciousness within the GMC. At present an outside company oversees the computer register.
GMC elections

General elections to the General Medical Council occur every five years, and the great problem with them is that so few doctors vote; about a third of doctors voted in the last general election.

The election works on the single transferable vote system, which the Merrison committee recommended as the best way to ensure the representativeness of the council. There are 42 seats in England, seven in Scotland, three in Wales, and two in Northern Ireland. The electoral process, which costs about £80,000, begins in February of the year of the election with notices in the medical press and “anybody who might possibly be interested” being told about the election. Any fully or provisionally registered medical practitioner or any practitioner who has held limited registration for a minimum aggregate of three years out of the four preceding years is eligible for election.

Nominations must be by six practitioners fulfilling the same criteria and must be in by the end of March. In 1984 there were 168 nominations for 39 places in England; this year there are 98 nominations for 42 places. The votes are counted by the Electoral Reform Society, which is confident that despite the candidates being listed in alphabetical order there is not a bias towards those with names closer to the beginning of the alphabet. Voting papers are sent out in May and must be returned by late June. They are accompanied by a list of the candidates that gives their name, address, qualifications, year of qualification and medical school, date of birth, and current principal appointment or field of practice. The results are announced in July, and the elected members begin in November.

The Merrison committee “encountered a good deal of disquiet about the difficulty of learning about candidates” and advocated that each candidate “should contribute, say, 50 words about himself” which would be sent out by the GMC. This has not happened and may be one of the reasons why the turnout in the election is so low. Or maybe, like the BMA do, however, sponsor candidates and circulate information on them through, for instance, the BMJ. In 1984, 21 of the 39 BMA candidates in England were elected, a success rate more than twice that for all candidates, which may have been done to win the extra information supplied. Some people worry that this sponsoring of candidates by the doctors’ association tips the balance of GMC interests towards the profession and away from the public.

Another issue that has given rise to debate is whether the large English constituency should be split into smaller constituencies, such that electors might have a closer relationship to the candidates and be more inclined to vote. The Electoral Reform Society advised against this on the grounds that it would have serious consequences for minority groups. The council’s working party on election procedures accepted this advice, and it has not happened.

The working party did not produce any other ideas on how to increase the turnout in the election, but the president of the GMC has recently been critical of the BMJ for acting as many doctors as possible to use their vote in the current elections (27 May, p 1414).

The GMC dislikes the media and dislikes criticism. Some members have reacted angrily to this series of articles, and critics of the council such as Jean Robinson and Marilyn Roseental tend to be labelled by council members and staff as atypical deviants. The council suffers the media rather than making use of them, perhaps failing to recognise that no matter how much it may dislike them it has no other way to communicate with the group—the public—to whom it should owe primary allegiance. The group of elected members suggested appointing a professional public relations officer with the idea that the council might become more proactive in its dealings with the public—leading rather than following. The BMA has set a formidable example of how this can be done.

The registrar was at the time against such an appointment, arguing that:

- the adoption of a deliberately high profile may create...
more problems than it solves. A solution may therefore lie not in actively seeking coverage on the basis of professional public relations advice, but in being more flexibly responsive to situations where the GMC can usefully do so.

The working party on the GMC in the 1990s opted for a compromise and recommended that “a member of staff should be trained to handle press and public relations matters on behalf of the council.” The council has, however, decided to appoint a full time press and public relations officer and the post has been advertised. But what may be needed more than a person to do the job is a change of attitude.

Workload, accommodation, and finance

The GMC has about 140 staff, who are housed on five sites and overworked. The registrar envisages that the workload will increase and that there will have to be more staff; he also wants the council to be housed on one site. These pressures (together with inflation) will inevitably mean that the annual retention fee will have to increase eventually. Figure 2 shows how it has increased from £2 since it was first introduced in 1970 to £30 now. One way to reduce the costs of the council and gather most of the staff on to one site would be to move the council to a part of the country where accommodation is cheap. This might have the advantage of making it easier to recruit secretaries and clerical staff. Even so, some accommodation would almost certainly need to be kept in London for meetings.

Conclusion

The GMC is too large: its staff are overloaded, its powers too concentrated, and its communications poor. The council’s many internal problems often seem to occupy members of the council and staff more than the pressing problems of improving education and competence and being seen to serve the public interest. In many ways it seems like an old fashioned body that resents the modern world.

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This is the final article in this series. Next week we will publish a response from Sir Robert Kilpatrick, president of the GMC.

Lesson of the Week

Nasal oxygen in exacerbations of ventilatory failure: an underappreciated risk

Robert J O Davies, Julian M Hopkin

In patients with ventilatory failure oxygen delivery through nasal prongs can lead to excessively high oxygen concentrations

Controlled oxygen delivery is an established treatment for severely hypoxic chronic obstructive airways disease and is important for the relief of cor pulmonale. Nasal spectacles or prongs provide a comfortable and convenient way of giving oxygen supplementation. In patients with an acute decompensation of chronic ventilatory failure and carbon dioxide retention, however, low rates of flow of nasal oxygen can deliver excessively high inspired oxygen concentrations, which progressively rise as ventilation falls. We present a case in which an oxygen flow rate of 1 l/min through standard nasal prongs delivered a fractional inspired oxygen concentration of about 40%, provoking severe carbon dioxide retention that resolved when oxygen was given through a Venturi mask. We also report results of a telephone survey of a small sample of junior hospital doctors, who are largely responsible for prescribing oxygen treatment.

In patients with ventilatory failure oxygen delivery through nasal prongs can lead to excessively high oxygen concentrations

Case report

A 67 year old woman was admitted feeling drowsy and confused. She suffered from severe chronic obstructive airways disease with chronic hypercapnia (forced expiratory volume in one second 0-3 litres, vital capacity 0-6 litres, usual arterial carbon dioxide tension 7-0 kPa). She had been treated at home with long term supplemental oxygen (2 l/min flow) through nasal prongs (disposable nasal oxygen cannula, Hudson). Her other treatment comprised a combination of frusemide 40 mg and amiloride 5 mg twice daily and salbutamol powder 200 µg four times daily.

On admission her temperature was normal and she had notable asterixis. A chest radiograph showed overinflated, emphysematous, clear lung fields. We isolated Branhamella catarrhalis from Gram stained cultures of sputum, which was treated with erythromycin stearate for five days. Bronchodilators were given by nebuliser. On admission analysis of arterial blood gases when she was receiving oxygen (2 l/min) through nasal prongs showed an excessive arterial oxygen tension of 17-0 kPa and an arterial carbon dioxide tension of 11-5 kPa (table I). We reduced the oxygen flow rate to 1 l/min and gave chest physiotherapy. Three hours later the arterial oxygen tension had risen further to 19-2 kPa. The patient’s clinical state remained poor with depressed consciousness and asterixis due to carbon dioxide retention. Oxygen treatment was stopped 25 minutes, and the arterial oxygen tension dropped to 3-9 kPa with a fall in arterial carbon dioxide and some arousal. An accurate 28% fractional inspired oxygen concentration was given by Venturi mask (Accurox mask, Bard) and no other treatment changed. She became fully oriented (arterial oxygen tension 7-7 kPa, arterial carbon dioxide tension 6-7 kPa).

Ten days later we carried out a trial of nasal prongs. After two hours of supplemental oxygen at 2 l/min her arterial oxygen tension was 15-1 kPa (table I). When she was breathing normal air the oxygen flow rate was