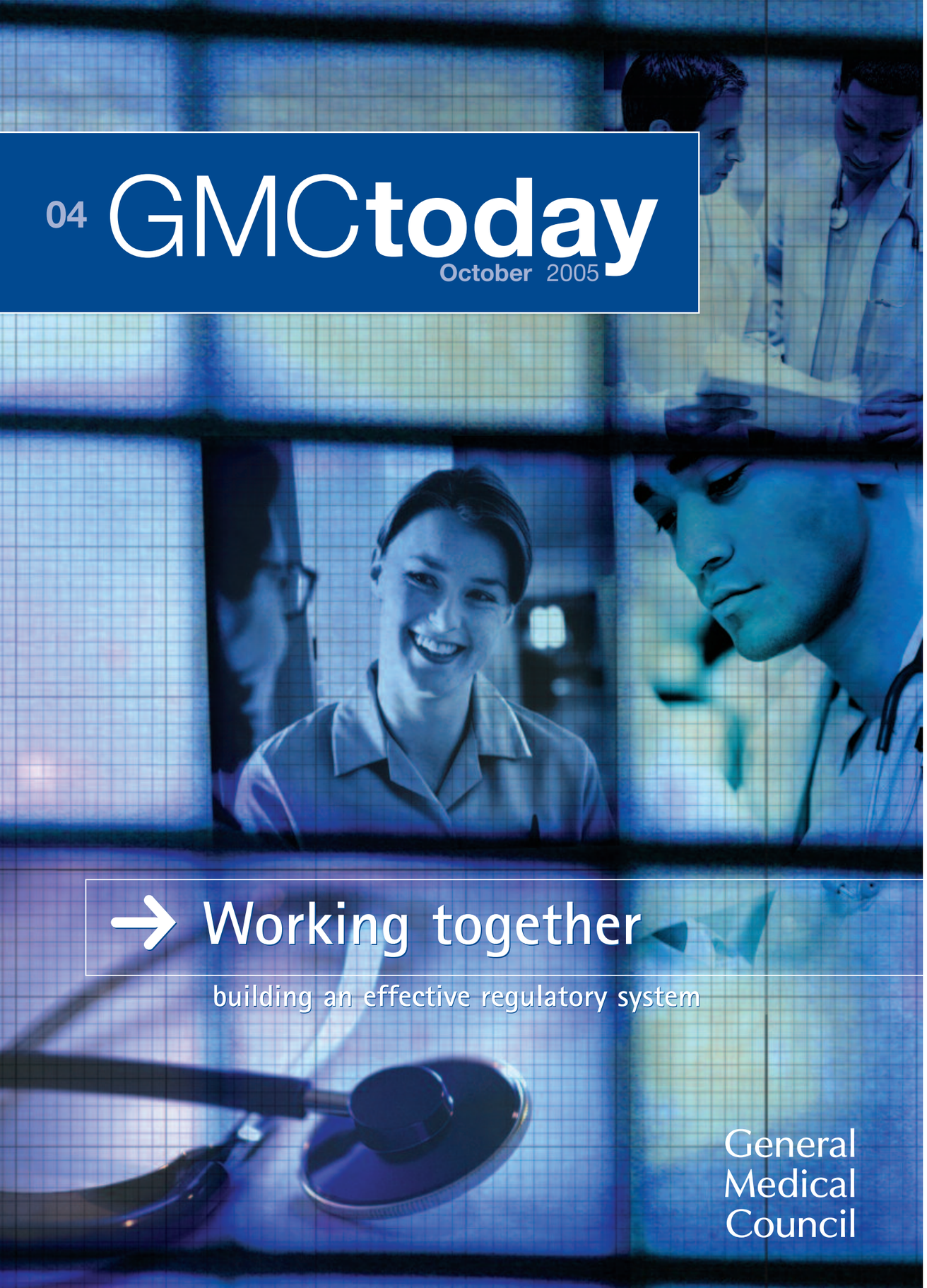

04 GMCtoday

October 2005

Working together

building an effective regulatory system

General Medical Council

Contents

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General Medical Council

Regulating doctors
Ensuring good medical practice

Vision

The GMC's vision is to be recognised as delivering and safeguarding the highest standards of medical ethics, education and practice, in the interests of patients, public and the profession.

The views expressed in articles contributed by external authors are those of the authors and are not necessarily shared by the GMC.

GMP consultation seminars

As announced in Issue 03, the GMC is consulting on a revised version of *Good Medical Practice*. The consultation will run until 30 November 2005. As well as asking for comments on the draft itself, we are finding other ways to explore the views of doctors and patients on what constitutes good medical practice.

We have commissioned the Picker Institute Europe to carry out research into patient, public and professional attitudes on the standards of care and competence expected of doctors. The research will consist of focus groups and interviews with a selection of patients, members of the public and doctors.

Also during the consultation period, the GMC will be hosting seminars around the UK on the theme of good medical practice. The seminars will take the form of a panel discussion focusing on issues arising from the new draft of GMP, including 'problem' patients, doctors' personal conduct, and patient choice vs clinical judgement. The GMC is inviting prominent figures from the worlds of medicine, media, politics and ethics to be members of the panel, and there will be an opportunity for questions and comments from an invited audience of doctors, patients and members of the public, who will vote on the issues before and after each debate.

If you are interested in attending any of the remaining seminars:

Cardiff *21 November, evening*
City Hall Debating Chamber

Edinburgh *22 November, evening*
Royal College of Physicians

Belfast *23 November, evening*
Waterfront Hall

please see the GMC's website **www.gmc-uk.org** for more information, and you can also submit your comments to the consultation online. Or you can contact the Standards and Ethics Team on 020 7189 5404 or email **gmpreview@gmc-uk.org**

Sir Graeme Catto
President, GMC

I can't begin to imagine how many times over the past year I have described the reforms taking place at the GMC. Our reform programme has been unprecedented in the history of the GMC and change has been a recurring theme at my meetings with doctors and patients.

Most of our reforms have been successful and have moved us in the right direction. The pace of change may appear slow but there is scope for further improvement and refinement of the detail. In particular, we want to make sure we iron out any unforeseen consequences of the reforms, building on what has been successful and taking corrective action when snags have been identified.

I am very aware that some aspects of our reformed fitness to practise procedures have proved highly controversial. For example, there is a widespread feeling that we have become too involved, or involved too early, in complaints that would be best addressed locally, at least in the first instance. I have considerable sympathy for that view.

Complaints against doctors may arise from a number of sources. To deal with them effectively, there needs to be clarity about respective roles. This is essential to ensure that legitimate concerns are pursued by the right organisation, at the right time and with the necessary thoroughness and fairness.

We argued, in our response to Sir Liam Donaldson's Call for Ideas, that, except where a complaint falls into a limited number of categories, there should be a presumption that it will be handled locally in the first instance and only passed to the GMC if that becomes justified by further, additional evidence. This would help to deal with complaints slipping through the net, duplication of resources across organisations, delay, and parallel investigations.

Meanwhile, our reforms have produced a better integrated, more coherent, way of dealing with allegations and concerns about doctors.

However, some aspects of the reformed procedures have led to uncertainty and disquiet. We have tackled issues as they emerged; and we believe that many initial concerns have been, or are being, addressed. For example, we were told by doctors that they found our standard letters threatening and unhelpful. That was certainly not our intention. We have, therefore, completed a fundamental review of all our standard letters, taking into account doctors' views.

The changed regulatory environment is explained further on pages 8 and 9. But there is one change taking place now to our procedures that requires mention here.

The procedures we implemented last November classified complaints as either serious enough to require immediate investigation or, on the face of it, not sufficiently serious for the GMC to be involved. Complaints in the latter category were referred to employers before deciding whether to close the file. This has led to problems and delays which have irritated both the doctors concerned and the complainants. We are now changing our procedures so that cases in this category are referred directly to the employing or contracting authority, who will determine how best to resolve the complaint. This means that we shall conclude this type of complaint much earlier, with less stress to well-meaning, competent doctors.

This and other changes are part of our move to a risk-based approach to regulation. We recognise that regulation is a partnership between the individual professional, the teams within which the profession works, the employer and the GMC. We believe we need to focus on education, registration, setting standards and on those areas where the standards we set may not be met. With good local systems we can do just that.

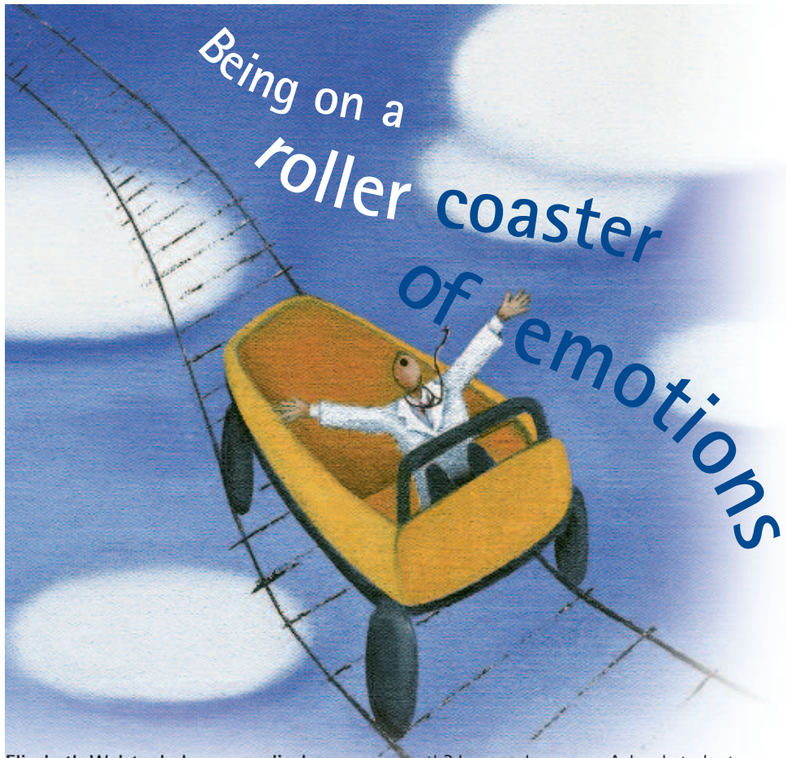
The principle we will adopt is to use our resources where they are most needed. We want to work in the public interest and ensure that doctors can get on with what they do best. Indeed, this 'light-touch' is an approach to regulation that is proving to be a successful model in many professions and industries; so it should not be a surprise that it can work well in medicine and I hope it will be widely supported.

At the turn of the year we expect Sir Liam Donaldson to publish the result of the review he has been undertaking since the publication of the fifth report of the Shipman Inquiry. I cannot forecast his conclusions but I am sure it will be wide ranging with considerable impact upon both local and national systems. (It is often forgotten that about half of Dame Janet Smith's recommendations in her fifth report related to local rather than GMC issues.)

We expect there to be great interest in that report. Consequently we propose to cover the issues under review in some depth in the December edition of *GMCtoday*. We are looking forward to what Sir Liam has to say. We believe that the publication of his report will bring a degree of certainty to many of the issues that have troubled regulation. That can only be good for our profession and for the public.

I fully recognise that we must maintain the confidence of doctors, while delivering our statutory purpose - to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The aim of the fitness to practise procedures is to deal firmly and fairly with the small minority of doctors whose fitness to practise may be in doubt. It is no-one's interest to allow the procedures to be misused or misapplied. Nor can it be in the interests of patients if the regulator is viewed as oppressive by the profession.

Sir Graeme Catto



Being on a roller coaster of emotions

Elizabeth Wolstenholme
Medical student
Keele University Medical School

Elizabeth Wolstenholme, a medical student at Keele University Medical School, Staffordshire, shares her thoughts about her final year.

I feel lucky. I am just about to start my final year at medical school and I know medicine is the right career for me. I can't think of anything else I would rather do or could achieve more in. I can't wait for the year to start so I can consolidate the last four years' hard work and put my training into practice as an 'apprentice doctor'.

I have always wanted to be a GP and the course has reinforced this. However, I have remained open minded and have enjoyed, and achieved in, other areas, from vascular surgery to paediatric diabetes, lung cancer to IV drug abuse and probation services as well as laboratory research. I intend to experience as much variety as possible again this year. Why waste the fantastic opportunities available to medical students?

So why, when people ask me whether I would recommend medicine, is my immediate reaction "no"?

This answer causes me great alarm. How can someone who has learnt and achieved so much at medical school professionally, academically and socially, feel that they cannot advise anyone to follow the same path? I remember, as an A-level student, talking to doctors about my ambition and being quite irritated by their equally negative answers to the same question. I think two reasons for these answers are fear and exhaustion, both very prominent for me and some peers at this stage.

So why, when people ask me whether I would recommend medicine, is my immediate reaction "no"?

I am not, and never have been, naïve to the future that faces me in medicine. My family are not medics, but I have worked in a hospital since I was 16. First, as a domestic, then, for the past five years, as a Healthcare Assistant in my 'spare time'. I have seen the true reality of medicine, from the gory to the glorious, the funny to the frustrating. However, my experience was lacking in one aspect – responsibility. The responsibilities I have now, only to increase in the future, are a dawning and very frightening prospect.

I am looking forward to working in a healthcare team, to being able to bounce ideas around and to further my knowledge. However, the expectations on me to contribute and to know something are daunting. Gone are the days of "sorry I have not covered that yet". Worse is the uncertainty of what I am expected to know. I am currently in a state of anxious confusion: I either don't know enough or I know enough but I don't know it.

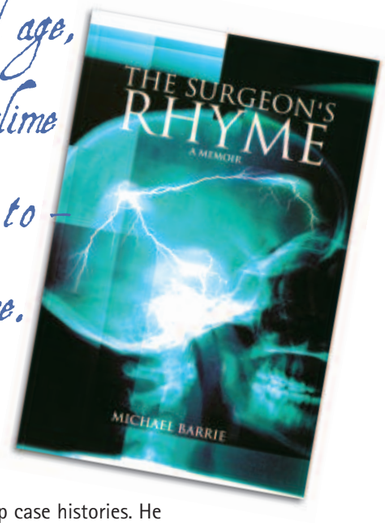
Medical school, and indeed any medical career, is exhausting if you really apply yourself. I am exhausted, not only from placements, projects and studying, but also because I have been on a roller coaster of emotions – something I anticipate will happen increasingly throughout the coming years. The stresses of continually starting new placements and exams will continue. In addition, as my knowledge and experience increase, so too does my appreciation of the impact of tragic circumstances on patients. Indeed, the flip side to this is giving positive news and experiencing the recovery of patients. Luckily for me at the moment, the power of the positive vastly outweighs the negative but I am anxious that this may change.

Evading negativity, I am able to discuss the truly amazing experiences I have encountered so far. I feel utterly privileged to have been invited to share the private lives and problems of patients. I am looking forward to this continuing. Although shocking and unbelievable at times, insights I have gained have made me less judgemental and more accepting. Yes, it has also made me cynical, disbelieving and weary of some, but I feel positive I will be able to maintain professionalism with all in the coming year.

With fear and tiredness aside, when I really think about the opening question, my answer has to be "yes, I would recommend medicine". Through the haze of work and uncertainty, I am standing on the starting block of year five and am looking forward to embarking on the treacherous lifelong journey of being a doctor.

Michael Barrie
GP and author of
The Surgeon's Rhyme
ISBN 1 85776 813 2

Heredity, sex and age,
Occupation, race and clime
The ills that men are subject to –
The vices of our time.



All patients great and small

When you step into the world of Michael Barrie, you are reminded of James Herriot. Despite the stresses of a GP's life, Michael makes you feel welcome, listening to your concerns no matter how trivial they are. You can see that he is truly passionate about his work. He has written a book about his working life, which was well received by his patients who queued up at Borders for a signed copy.

Michael Barrie signs copies at Borders for his most avid readers, his own family!

His book, *The Surgeon's Rhyme*, describes Michael's life from his early medical student days to present day practice as a GP, based in Kingston-upon-Thames.

"My original title was *All Patients Great and Small*," said Michael, "but I changed it to *The Surgeon's Rhyme*, attributed to Eric Finch's ditty to help students work out the cause of a disease".

'Heredity, sex and age,
Occupation, race and clime
The ills that men are subject to –
The vices of our time.'

"Even today I still use the rhyme in practice. I love the diagnostic challenge, having to work out in often less than 10 minutes what is wrong with the patient".

The book came about when he had to write up case histories. He started to collate them and needed a central thread – the surgeon's rhyme – to structure it.

Michael recalls vividly the scenes from his student life, his encounters with patients, the socially unacceptable Victorian psychiatric institutions and emotional turbulence involved.

Life as a GP isn't always wonderful. There is too much paperwork. When asked how he would improve it, Michael replied:

"Firstly, I would ask for less political interference. The Access initiative also does not work. Gaining points to earn cash isn't right. There's a tendency to provide services and take blood pressures when they are not always needed. It is wrong that patients have to grovel with the receptionists to get an appointment for the same day. We have 6,800 patients. If the Government provided us with a fourth doctor, this would help cut down waiting lists and ensure patients are seen more quickly.

"Dentists have 20 minute appointments with patients, so why can't GPs?"

The GP is often 'piggy in the middle', being expected to act as marriage counsellor when families disagree over treatment, for example, movingly explained by Michael.

Michael believes that the public need to be educated to reduce the amount of time wasted at practices. Approximately 85% of patients are the 'worried well'. There's nothing actually wrong with them. "For some, going to see the doctor is a social occasion – the one person they'll talk to that day. You've got to be honest with that patient, saying you've only got 10 minutes".

A colleague's surgery gets round that by holding coffee mornings, kept separate from the GPs so that they can deal with the real ailments.

So will Michael be writing any more books? He is thinking of writing a novel when he has more time. Patients are certainly looking forward to further reading from their local hero.

Is the NHS immune to fraud?

Ahmer Kunwar
Internal and External Communications Manager, NHS Counter Fraud and Security Management

Ask health professionals about fraud in the NHS and you discover that the concept has, until recently, been little talked about. In September 1998, the NHS Counter Fraud Service (NHS CFS) was set up to address the issue. Six years later, and with a financial benefit to the NHS totalling £675 million, fraud is not only being talked about; it is being addressed and tackled.

Following the success of the NHS CFS, the NHS Counter Fraud and Security Management Service (NHS CFSMS) was launched in England and Wales on 1 April 2003 as a Special Health Authority with responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the NHS.

In the largest organisation in Europe, even a small proportion of fraudulent staff and patients has a huge impact.

Most people who work in and use the NHS are honest, but there is a minority that tries to defraud it of its valuable resources. By working to reduce fraud and corruption to an absolute minimum and hold it there permanently, the NHS CFSMS can release these resources for better patient care.

In the largest organisation in Europe, even a small proportion of fraudulent staff and patients has a huge impact. Fraud is committed by a range of NHS professionals, who might claim for work not undertaken, alter prescriptions, create ghost patients or make fraudulent claims for out of hours visits, advice not given or treatment not provided. In some areas, claims by NHS professionals fell by between 43% and 54% after processes were fraud-proofed.

It is now accepted that even the NHS is not immune to fraud. One of the NHS CFSMS's primary aims was the creation of an anti-fraud culture, and it has set about this in a variety of ways – giving over 1,400 fraud awareness presentations to key NHS staff, agreeing counter fraud charters with an ever-increasing range of regulatory bodies and organising an annual Fraud Awareness Month (FAM). Now in its third year, FAM has proven highly successful, reaching a total audience of 6.1 million in October 2004. This year, FAM is expected to have an even bigger impact, with visits planned to more than 159 NHS sites, and a heavy media campaign.

During October 2005, the NHS CFSMS will be visiting NHS bodies across England and Wales to raise awareness of fraud and corruption in the health service and explain how staff can help tackle it. See **www.cfsms.nhs.uk** for further details of our programme of visits.

A heavy media campaign helps raise fraud awareness

The NHS CFSMS has already achieved a great deal – from raising awareness about fraud to sharing best practice. We can also quantify our successes:

We have cut overall losses in the area of patient fraud by 54% from £171 million to £78 million.

- We have provided a total financial benefit of £675 million to the NHS – a phenomenal 13:1 return on investment.
- We have cut overall losses in the area of patient fraud by 54% from £171 million to £78 million.
- More than 980,000 NHS staff and professionals are covered by counter fraud charter agreements.
- We have a remarkable 96% successful prosecution rate and have secured 292 successful criminal prosecutions.

If you have a concern about a fraud taking place within the NHS, please call the confidential NHS Fraud and Corruption Reporting Line on 0800 028 40 60. All calls will be dealt with by trained staff and professionally investigated. Lines are open Monday to Friday 8 am–6 pm. You can also email us at **nhsfraud@cfsms.nhs.uk** at any time.

Please visit our website at **www.cfsms.nhs.uk** to find out more about the work of the NHS CFSMS.

GP Register

On 31 March 2006, the GMC will introduce a register of doctors who are eligible to work in general practice in the National Health Service in the UK. From 31 March 2006, all doctors working in general practice, other than GP registrars, will be required to be on the GP Register. The registration requirement will extend to all GPs working in the NHS, including locums. Doctors who are training for general practice (GP registrars) will not need to be on the GP Register.

Primary care organisations (PCO means a primary care trust in England, Health and Social Services Boards in Northern Ireland, a local health board in Wales, and primary care divisions within area health boards in Scotland) will continue to maintain primary medical performers lists after the introduction of the GP Register. GP registration will be a requirement for entry to a medical performers list for GPs, except for GP registrars.

The GP Register is being introduced alongside the changes to the system for postgraduate medical education and training under The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. Those changes include the establishment of the Postgraduate Medical Education and Training Board (PMETB), which formally assumed its functions on 30 September 2005 (see p16).

Benefits of the GP Register

The GP Register will provide a number of benefits. In particular, employers and contracting authorities, and patients and the public, will, for the first time, have access to a definitive, and comprehensive, national register of doctors who are eligible to work as GPs. The GP Register will increase patient safety, and contribute to a raising of standards, by helping to prevent doctors working as GPs who are not entitled to do so.

Creating the GP Register

It is vital that doctors who wish to continue practising as a GP in the NHS are included in the GP Register on 31 March 2006.

We aim to make the introduction of the GP Register as trouble-free as possible, and to minimise any risk of disruption for doctors or PCOs. We want to ensure that we carry onto the GP Register the names of all eligible doctors and that the information we hold on them is up to date and accurate.

We are, therefore, as far as possible populating the GP Register with the names of eligible doctors, by drawing data from the medical performers lists held by PCOs. We are grateful to PCOs for their ready co-operation and their support.

What GPs should do now

If you are currently on a medical performers list

you need do nothing for the time being. Between mid-November 2005 and early February 2006 you will receive a letter explaining the new system and asking you to confirm the accuracy of the data held by your PCO. The letter will be distributed by your PCO on the GMC's behalf.

Provided you wish your name to go forward to the GP Register, you need do nothing. If you do not wish your name to go forward – which will mean you will be unable to practise as a GP in the NHS after 31 March 2006 – or if there is an inaccuracy in the data held, you will need to let the GMC and your PCO know.

If you have not received a letter by the end of February 2006, please contact us by emailing **gpregister@gmc-uk.org** (quoting your full name and GMC reference number) and we will explain what you need to do to apply for inclusion in the GP Register.

We will write to you when the new GP Register goes live to confirm your inclusion.

If you are not currently on a medical performers list

but want to be on the GP Register and meet the prescribed criteria for entry, you will need to apply directly to the GMC. Please contact the GMC by emailing **gpregister@gmc-uk.org** and we will explain what you need to do to apply for inclusion in the GP Register. Or you can access **www.gmc-uk.org** for an application form and fact sheet.

If you are a GP registrar

your position will not change with the introduction of the GP Register. You will need, as now, to join a medical performers list. However, you will not need to be on the GP Register to complete your training. You will be eligible for inclusion in the GP Register when you have completed your training and hold a CCT, or are awarded a certificate of equivalence, from PMETB.

Contact centre

0845 357 3456

registrationhelp@gmc-uk.org

Q How can I check if I am currently registered?

A We have two automated ways to check your registration status, available 24 hours a day: you can phone the registration advice line on 0845 357 3456 and select option 1 and then when prompted key in your registration number – the service will confirm your name and registration status; you can also check your registration status from our home page under the heading *Medical Register - Checking a doctor's registration.* Alternatively you can speak to someone by phoning the registration advice line, not selecting any option and speaking to one of our registration advisers.

Q Can I pay for my ARF (Annual Retention Fee) by credit card over the telephone?

A We are unable to take payment over the telephone. We do, however, accept payments by cheque or bank transfer. You can also pay on our website **www.gmc-uk.org** via MyGMC. This enables doctors to pay by credit card over the Internet.

Q What else can I do on MyGMC?

A As well as paying, you can check your registration details, and update your address, contact and personal details at your convenience. You can also check your account and payment status. There will also be an opportunity to take part in surveys to offer your opinion to the GMC.

Cover Story

'The best way of delivering revalidation will be through local systems where they operate effectively'

Working together to build an effective regulatory system

In recognising that the GMC cannot survey the entire population of 120,000 doctors in active practice in the UK all the time, we have promoted a four-layer model of medical regulation which we believe provides a helpful framework.

Personal regulation: which reflects the way in which individual doctors regulate themselves, based upon their commitment to a common set of ethics, values and principles, which puts patients first.

Team-based regulation: which reflects the increasing importance of team working and requires health professionals to take responsibility for the performance of the team and to act if a colleague's conduct, performance or health is placing patients at risk.

Workplace regulation: which reflects the responsibility that the NHS and other healthcare providers have for ensuring that their staff, and those who use their facilities, are fit for their roles. Workplace regulation is expressed through clinical governance and performance management systems.

Professional regulation: which is undertaken by the GMC and other statutory health regulators and, for example, by medical royal colleges where appropriate. Professional regulation is expressed through work on standards, education, registration and licensing, including revalidation, and fitness to practise procedures.

'The great majority of doctors in the UK are good doctors, delivering safe and effective healthcare, often under difficult and demanding conditions.'

Building on this framework, and using a risk-based approach to regulation, the GMC will ensure its resources are applied where they can be most effective. The great majority of doctors in the UK are good doctors, delivering safe and effective healthcare, often under difficult and demanding conditions. We must work with others to ensure that standards remain high and that prompt and effective action is taken to deal with actual or emerging impairment. It is on this presumption that we have made our plans which, we believe, will make an important contribution to the debate on the future of regulation.

In this and the December edition of *GMCtoday* we will look at how local and national systems can work together to build an effective system of regulation that will merit the confidence of patients and the public.

'We look in particular to employers to ensure that standards are maintained at a local level. It is important too that local contractual and operational standards should enhance and not contradict the values of individual good medical practice.'

Local processes

The regulatory landscape has seen much change recently with the introduction of clinical governance; the establishment of new national quality assurance agencies; and the GMC's own radical reform programme.

The new, evolving, model reflects better the needs and demands of today's society. However a major challenge is the need to ensure that the various players' roles and responsibilities are clear; and that they connect effectively and coherently.

Interface between national and local regulation

We see our role as setting professional values and standards at national level and working - with others - to protect patients and the public in cases where those values and standards are not met. This cannot happen effectively in isolation.

We look in particular to employers to ensure that standards are maintained at a local level. It is important too that local contractual and operational standards should enhance and not contradict the values of individual good medical practice.

Both we and employers have a duty to see that our respective responsibilities interface effectively. This is essential if we are to identify and report poor performance at an early stage and to underpin revalidation. We expect to work closely with employing authorities so we can provide them with any relevant research or information which helps them spot warning signals and intervene before a failure in medical care, rather than afterwards.

Patient and public confidence must be supported by other objective data too, such as information about individuals' clinical outcomes. This requires effective local systems capable of complementing, but not replacing, personal regulation. Employing authorities need to accept responsibility for the performance and conduct of those whom they employ or contract, and to generate and evaluate the data that will enable them to discharge that responsibility. But the systems to support this are not yet fully embedded.

Quality assuring local systems

The national quality assurance agencies must play their part in supporting the process too. Effective regulation of individuals relies on effective regulation of the systems within which they work – which means robust quality assurance of the local systems upon which revalidation will depend, co-ordination of organisational and professional standards, sharing of information about dysfunctional practice and co-operation to reduce the regulatory burden on individuals and organisations. We have welcomed the Healthcare Commission's decision to refresh and develop its concordat with inspecting, auditing and regulating bodies in England and the impetus this will give to improving patient services and reducing the burden of inspection.

A risk-based approach

The best way of delivering revalidation will be through local systems where they operate effectively, along the lines of the criteria outlined above. In this kind of 'approved environment', we will be able to rely substantially on local systems of appraisal and clinical governance to provide evidence that doctors are up to date and fit to practise. This will help to minimise the administrative burden for both doctors and employers.

But doctors working outside approved environments will not be able to supply evidence from the workplace of their fitness to practise.

Doctors in groups that appear to present a higher degree of risk would be subject to a higher degree of direct GMC scrutiny. It is important to stress that this scrutiny might well reveal no need for further action.

As part of the process of issuing doctors with a licence, we propose to collect information about their practice and the environments in which they work. We may then want to prioritise the revalidation of doctors who are not working within a GMC approved environment over those who are. This will help us simultaneously to improve safety and lessen the regulatory burden on doctors who give no cause for concern.

We plan to use patient and colleague questionnaires to identify concerns about the fitness to practise of doctors working outside approved environments. A pilot research project from Leeds University has suggested that these questionnaires are a potentially valid, reliable and practical means of gathering evidence. We have commissioned CEFP and Peninsula Medical School to continue work on the validity and reliability of the questionnaires; and to develop operational rules.

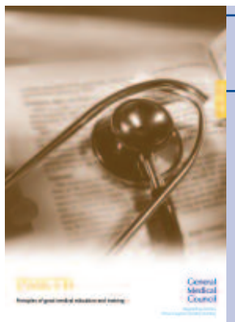
The Standards & Ethics Committee, working with the Department of Health and the Royal College of Psychiatrists, has prepared the following advice to explain how the guidance on delegation and referral in Good Medical Practice *applies to consultant psychiatrists working in multi-disciplinary teams.*

Accountability in multi-disciplinary and multi-agency mental health teams

Consultants' roles and responsibilities are developing and changing. They vary according to both the specialty and the type of healthcare environment in which they are provided. Changing working practices, such as multi-disciplinary and multi-agency team work, and changes in the range of skills and competencies of other healthcare practitioners, present a number of opportunities as well as challenges in providing safe and effective care. Many of the issues are best resolved by clarity between consultants and their employing organisation about appropriate roles and responsibilities. Consultants should raise with their employing bodies any issues where ambiguity or uncertainty about responsibilities may arise. Consultants also need to be clear about the expectations of the GMC.

All doctors are accountable to the GMC for their conduct and the decisions they take. *Good Medical Practice* (2001) sets out the principles which should underpin their professional work and against which their conduct may be judged. *Good Medical Practice* does not try to address, in detail, all the circumstances in which doctors may work. This guidance explains how the principles in *Good Medical Practice* apply to doctors working in multi-disciplinary or multi-agency mental health teams.

- Doctors should be competent in all aspects of their work including: reviewing and auditing the standards of the care they provide; training and supervising colleagues; and, where they have direct line management responsibility, managing staff and the performance of the teams in which they work.
- Doctors should do their best to ensure that the systems in which they are working provide a good standard of care to patients. Where doctors cannot be satisfied, nor take steps to resolve problems, they should draw the matter to the attention of their trust or other employing or contracting body.
- To these ends, doctors should establish clearly with their employing or contracting body both the scope and the responsibilities of their role. This includes clarifying: lines of accountability for the care provided to individual patients; any leadership roles and/or line management responsibilities that they hold for colleagues or staff; and responsibilities for the quality and standards of care provided by the teams of which they are a member. This is particularly important in circumstances in which responsibility for providing care is spread between a number of practitioners and/or different agencies.
- Doctors are not accountable to the GMC for the decisions and actions of other clinicians. This means that if a consultant delegates assessment, treatment and care to a more junior doctor, the consultant is not accountable to the GMC for the decisions or actions of the junior doctor; however the consultant is responsible for ensuring that the junior doctor is appropriately trained, experienced and supervised.
- Psychiatrists can delegate the care of those patients for whom they agree to take responsibility. But many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multi-disciplinary teams of which they are a member may provide health and social care services to a substantial number of patients. Referrals are made directly to such teams, and decisions about allocation to an appropriate professional are made according to the teams' policies. In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team.
- In these multi-disciplinary teams, consultants oversee a group of patients who are allocated to their care, and are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team. However, in accordance with paragraph 2, they must do their best to ensure that arrangements are in place to monitor standards of care, and to identify potential or current problems. They should notify their employer about any unresolved concerns or problems.



Educational guidance published

New guidance has been published on medical education and training. *The Principles of Good Medical Education and Training* sets out aspirational, yet achievable, criteria for use by anyone designing a programme or course at any stage from undergraduate degrees to Continuing Professional Development (CPD). It can be found on our website **www.gmc-uk.org** under *Education*, and *Education Publications*.

This is a joint publication of the GMC's Education Committee and the Postgraduate Medical Education and Training Board (PMETB) and is available on both the GMC and PMETB websites. The principles underpin the guidance issued by the GMC Education Committee and by PMETB. The principles are, necessarily, broad and generic.

The joint publication of this document cements the relationship between the two regulators. Having the same principles underpin all the guidance for medical education and training will help to ensure that education and training is a continuum throughout the careers of medical students and doctors.

Principles of Good Medical Education and Training has been awarded a Crystal Mark by the Plain English Campaign.

Students debate national assessment

On 1 September, Oxford Medical School fifth and sixth year students at the John Radcliffe Hospital debated national assessment. This was a pilot event, inspired by Professor Chris Bulstrode, designed to get students to feed back on the Education Committee's consultation on the strategic options for undergraduate medical education.

Colin Chu, President of the Medical Students Association, organised and chaired the debate. The motion was: 'This house would support a nationalised finals examination'. Rasheed Zakaria and Helen Woodward proposed the motion and Catherine Quarini and Sandy Douglas opposed. The debate was then opened to the floor. Over 150 medical students filled the lecture hall to hear the pros and cons of a national assessment.

The proponents argued that national assessment would build on *Tomorrow's Doctors* and that, one way or another, curricula will be more tightly defined in the future. A national examination would be fair and consistent.

The opponents argued that national assessment would create unfair league tables of schools and ranking of students and would reduce diversity between medical schools. It would also be unnecessary with the development of the Foundation Programme.

A fire alarm brought this rousing discussion from the floor to an abrupt halt. Those happy to continue the debate decamped to a nearby garden

Colin then called for a vote by feet - In a division on the lawn, 55 were in favour of a 'nationalised finals examination', 27 were against and four abstained.

The group agreed to think more about the different options in the consultation and will feed back to the GMC as part of the consultation. The consultation runs until 31 October 2005, so there is still time to let us know what you think about introducing a national assessment, and a student register, and what broad principles should underpin the undergraduate medical curriculum. Visit the Education section of **www.gmc-uk.org** to see the consultation and supporting documents on our website.

Developing partnership-based regulation

Professionally led regulation in partnership with the public and patients is fundamental to ensuring that the GMC is fit for purpose in modern society. We are in the middle of a year-long development plan to enhance the level of patient and public involvement in our work and are making progress.

What do people think?

Knowing what people think is crucial to ensuring that the policy we develop makes sense. Last year we undertook a pilot attitude survey of the public and doctors. The survey commissioned from MORI and NOP World explored a range of key issues relating to medical treatment and regulation.

Topics ranged from attitudes relating to consent, confidentiality, state of the regulatory system, fitness to practise and revalidation. Results show that there are substantial areas of agreement between the GMC's vision for the future of medical regulation and public and professional expectations.

Perhaps the clearest feature, overall, is many respondents' lack of detailed awareness of the regulatory system and of the role of the GMC within that system.

Four out of five patients said they have confidence in their doctor and that this confidence is strongly influenced by the doctor's ability to provide appropriate information, and by the doctor's level of communication and interpersonal skills. Seven per cent lack confidence in their doctor, due to poor listening and communication skills.

At least three quarters of both GPs and hospital doctors agree that communication and interpersonal skills are key to developing a good relationship with patients.

One in five GPs stated that they are confident in regulation provided by local governance and the GMC. Some disagree and many are undecided. However, responses to follow-up questions suggest that respondents remain confident in the appropriateness of local systems in the overall regulatory framework.

Fifty-two per cent of GPs and 48% of hospital doctors are confident that the information generated locally through clinical governance should provide the basis for revalidation: however a significant proportion (30% of GPs and 27% of hospital doctors) neither agree nor disagree/don't know.

Overall, the results provide evidence of strong support for key parts of our vision for the future of professionally led regulation as expressed in *Developing medical regulation: a vision for the future.*

What else are we doing?

Apart from involving the public in the review of *Good Medical Practice* (see page 2) and national assessment proposals (see above), we are also:

- holding a citizens' jury on our guidance on the treatment of children, organised by Opinion Leader Research, in November
- further developing patient and public reference groups so that they can have a say in our policy development
- working with other health and social care councils to produce a leaflet for patients and the public on the role of the regulators and contact details
- launching our new website and revamping an online doctor search facility to make it easier to use (see page 12)
- consulting widely on the improvement of the specialist register
- establishing a readers' panel.

These are just a few initiatives planned. Effective partnership and engagement with patients and the public is crucial, and we hope to see that relationship improving year on year.

GMC Online

The GMC's website relaunched

www.gmc-uk.org

The GMC has redesigned its website following a Communications Review last year which highlighted the need for improvement. The home page reflects the interests of doctors, and pharmacists as well as the media and the general public. This will make it easier and faster for you to find information relevant to your needs.

The new website at **www.gmc-uk.org** reflects the current best practice for website design and navigation.

How will doctors find the website useful?

Apart from the latest news from GMC you will find on the home page the following different categories of information:

The medical register

This provides information on the Medical Register and explains how you can check your details. By keeping up-to-date registers of qualified doctors, we aim to ensure that all registered doctors maintain the standards the public and the medical profession expect. There is also useful information on our proposals for licensing and revalidation.

Registration for doctors

This explains how you can register with the GMC as a doctor, and there is also a section that describes what happens after you have registered. There is also information on fees, and a link to our licensing and revalidation proposals as well as PLAB.

Guidance on good practice

This provides guidance on a number of issues to help you ensure that you comply with Good Medical Practice. The guidance published in this section outlines the ethical standards that all doctors should follow in their work. Case studies show how guidance applies in practice. Also, you can find archived guidance if you are carrying out any research.

Education

This provides guidance on the training and development of medical undergraduates and postgraduates, SHOs, PRHOs, etc.

Publications

This takes you to the current publications available from the GMC. If you are interested in archived guidance, there will be a link to the Publications Scheme which is part of the Freedom of Information page.

The home page will also link you to *GMCtoday* where you can view archived copies along with the latest issue. There is a link to the Press Office and links to the GMCWales and GMCScotland pages are also easily visible.

New Online Doctor Search

One of the GMC's key initiatives this year has been to introduce a wider ranging online doctor search facility. The new Online Doctor Search (ODS) provides a much improved service, allowing 24-hour access if you want to check your registration details.

This will enable pharmacists to check doctors' registration details at any time of the day and medical staffing officers to check for employment information at short notice, which will help locums.

But it also follows our duty to provide information on undertakings and conditions so that the general public have access to registration/fitness to practise information, with the exception of any confidential conditions or undertakings relating exclusively to a doctor's health.

Any enquirer, by means of a simple search, can reveal a doctor's GMC registration number, name, gender, postal town and dates of provisional, limited, full and specialist registration, where relevant, and fitness to practise information. The facility means that the public can now access all this data through one part of the GMC website, rather than finding out about fitness to practise through a separate section of the site.

The enquirer will be able to see if the doctor is suspended and the detail of any conditions or undertakings. It will give information about all doctors with current restrictions on their registration as well as those who have a warning. Users will also be able to view historical conditions and warnings that have been current since the launch date (restrictions that expired before this date will not be shown); minutes relating to conditions, suspensions and erasures; and appearances before hearings.

The ODS can be found by visiting **www.gmc-uk.org** and clicking on *The Medical Register* then *Check a doctor's registration*.

Basic medical sciences are the bedrock of medicine

Regarding Issue 02 *GMCtoday* as to whether there should be a national assessment for medical students.

With curricula now in problem-solving mode in many medical schools, and with much personal responsibility being given to the medical student to acquire the necessary knowledge and skills, it is essential that significant deficiencies and omissions do not occur. As an academic with 50 years' experience of teaching medical students, I am sure this is especially important in the basic medical sciences. They are and must remain the bedrock of medicine.

It is all very well to train doctors in ethics and to have good communication skills, but if there is a lack of basic knowledge they are of little use to the patient. *Student BMA News* p4, April 2005, reported that 47% of students stated their medical course had not given them sufficient anatomy knowledge.

In Aberdeen (*Clin.Anat.* 18, 380, 2005) most clinicians felt that the current anatomical education of medical students is inadequate and below the minimum necessary for safe medical practice. Moreover, inadequate training in the basic medical sciences has important repercussions for postgraduate training.

There should be a National Medical Training Council with responsibility not only for assessment of students at a national level but also, at a mandatory level, for defining in detail a balanced curriculum as a foundation for all medical schools to ensure that basic subjects needed for safe and effective clinical practice are adequately taught.

This must not only take into account the need of primary medical education for undergraduates to become doctors, but also to ensure that sound foundations are laid for subsequent secondary postgraduate education and specialisation. The composition of the NMTC should be catholic including the basic medical sciences, clinical sciences, and the Royal Colleges. It should also include representation of the GMC, BMA and the recipients of medical education, the medical students themselves.

Professor P F Harris

Curtains for MRSA

As far as I am aware, nobody has mentioned the ubiquitous and dangerous bed curtains. These are touched regularly by staff, particularly nurses and care assistants.

When my mother was in hospital, at a pre-terminal stage, she became a carrier. The care assistants regularly drew the curtains to clean her, but then went backwards and forwards through the curtains on average three or four times, because they had not provided themselves with the dressings or other items required.

They put on gloves, but of course these rapidly became contaminated. These contaminants must have been transferred to the curtains, only to spread to the next pair of gloves, used on the adjacent patient.

Incidentally, when my wife came to England in 1967, she noticed immediately the poor standard of hospital cleaning. This was well before contracting out of services. It seems that it was due to poor knowledge and training in elementary cleaning techniques. Perhaps the (fairly junior) managers involved should visit the Continent, at taxpayers' expense – rather than more senior managers who could probably afford their own fares.

Dr M G Wright FRCP

If you want to give your views on features or articles in *GMCtoday*, or if there is an issue you think our readership needs to know about, please write to us or send an email: **gmctoday@gmc-uk.org**

Send your letters to:
Jane Janaway, *GMCtoday* Editor, PCA,
General Medical Council, 5th Floor, St James's Buildings,
79 Oxford Street, Manchester, M1 6FQ.

Test your skills

Seven questions with thanks from the Royal College of Surgeons. Intercollegiate MRCS Part 1 sample multiple choice questions. Applied basic sciences.

1 Metastatic calcification:
A occurs in normal tissue
B is characterised by psammoma bodies
C is associated with hyperparathyroidism
D characteristically occurs in osteoarthritis

2 Complications of an above-knee amputation include:
A mental depression
B Sudeck's atrophy
C myoglobinuria
D neuroma formation
E amyloid deposition

3 The cephalic vein:
A begins in the region of the anatomical snuffbox
B at the elbow is deep to the lateral cutaneous nerve of the forearm
C ends by joining the brachial vein
D is medial to the biceps muscle in the arm
E has no valves

4 Pathological fractures occur in patients with:
A osteomyelitis
B osteoporosis
C osteomalacia
D osteitis fibrosa cystica

5 Occlusion of the right posterior cerebral artery produces:
A blindness of the right eye
B right homonymous hemianopia
C bitemporal hemianopia
D an absent light reflex
E extraocular muscle paralysis

6 The adductor (subsartorial) canal contains the:
A vastus lateralis muscle in its lateral aspect
B profunda femoris vessels
C femoral arterial branch which takes part in the anastomosis around the knee
D nerve to the vastus medialis muscle
E saphenous nerve

7 A cervical rib is:
A a cause of brachial artery aneurysm
B best diagnosed by postero-anterior chest X-ray
C a cause of thoracic outlet syndrome
D most commonly symptomatic in the 50- to 60-year-old age group

A question of ethics

Roger Worthington, PhD, Adviser, GMC Standards and Ethics, reviews Stephen Wilkinson's book:
Bodies for Sale: Ethics and exploitation in the human body trade.

The idea of selling human bodies may appear sensationalist but a serious ethical debate is developing around topics such as the patentability of human genes, commercial surrogacy, and trade in body parts taken from live donors.

For some readers, their initial response may be to question how such activity could be ethically sustainable, but Wilkinson deconstructs various arguments, for example, about validity of consent and commodification, and concludes that many (though not all) objections are either weak or difficult to sustain.

Discussion is presented in a way that points towards a liberalising agenda, but one supported by a regulatory framework. He questions what makes selling human kidneys, paying women to be surrogates, or patenting human genetic sequences fundamentally immoral.

If the morality problem is solved then amending the law by extending the scope of regulation, such as that embodied in the Human Fertilisation and Embryology Act, may offer a way forward. Criminalising types of behaviour could even be counter-productive and lead to conduct that is less moral than the alternatives, or more exploitative of vulnerable human beings.

There are benefits to be had for society in terms of increasing the supply of donor organs, promoting scientific research and increasing the range of options open to women in terms of reproductive choice. While risks may be attached to some of these benefits, to society and to the individual, making available safe controls and reliable information about probability and risk would at least afford potential patients some measure of protection.

Whatever one's own point of view, the logical way in which material is presented in this book is one of its strengths, as too is its very readable prose. Overall, it makes a valuable contribution to the debate about public policy on some interesting and controversial topics.

Routledge. 248pp. £18.99 (paper)
ISBN 0415266254

→Dr to Dr

If you wish to advertise in Dr to Dr, simply email **gmctoday@gmc-uk.org** *with the details. Ads are free. The copy deadline for the December issue is November 9.*

HOLIDAY ACCOMMODATION

→ **Amfilohia, Greece:** Apartment, sleeps 4, fully furnished. 10 mins from seaside, 5 mins from shops and restaurants. 1 hour drive from Lefkada island. Nearest airport: Preveza (Aktio). From £150 pw. Tel: Maria on 02920317457, or email: mandrikoula@doctors.org.uk

→ **Comrie, Perthshire:** Delightful cottage sleeping 8 in 4 bedrooms - 2 en-suite. Excellent walking, fishing and golf. Linen and towels provided. Tel: 01764 671003, email: mallan2@btopenworld.com or visit: www.glencottagecomrie.co.uk

→ **Coral Bay, Cyprus:** Lovely 3 bedroom air-conditioned villa, sleeping 6, with private pool and sea and mountain views in Peyia village overlooking Coral Bay. 5 mins drive to Coral Bay beach and close to Paphos Harbour, The Akamas National Park nature trails and Lara Bay Turtle Conservation Project. Prices from £375 per week. email: villa.auriga@btinternet.com

→ **Cyprus, Pissouri Bay:** 2-3 bedroom house sleeping 5-6 in the beautiful and tranquil resort of Pissouri Bay. Fully equipped kitchen including washer, 2 bathrooms and air conditioning in every room. Attractive secluded garden. Close to the beach, shops and tavernas. Windsurfing and other water sports, golf and bike hire. From £250 per week. email John or Sharon on sas@spkmn.freeserve.co.uk

→ **Isle of Arran, Scotland:** 4 bedroom, newly built self-catering villa in tranquil surroundings. Within easy travel of 7 golf courses, hillwalking, sea-trips. Heating, electricity, towels and linen included. Widescreen TV, DVD, video. Sleeps 8 (+2 kids). Tel: Jim and Moira on 01586 830323 www.arranselfcatering.com

→ **Koh Samui, Thailand:** 2 bedroom, air-conditioned house. Large balcony with magnificent panoramic sea views. 3 mins walk to an empty beach. Self-contained, comfortably sleeps 4. Available all year round. Check www.samuihomeandgarden.com for further details.

→ **Lagos, Algarve:** Beautiful villa with sea views. 4 double bedrooms, 4 bathrooms, pool, air conditioning and heating. Lagos town, beaches, marina - all within walking distance. Golf course 5 mins drive. 40 mins drive from Faro airport. Offer rate per week: £700 for 5-9 people, £500 for 3-4, £350 for 1-2 persons. Tel: 07717833617 or davidbickerton@onetel.com

→ **Luz, Western Algarve:** 2 bedroom villa with private pool. Sleeps 4. Within walking distance of beach and restaurants. Easy access to golf courses. Tel: 01924 894518, email: casaluz@hotmail.co.uk

→ **Moray, Scotland:** 4 star cottage (sleeps up to 4) beside the Inner Moray Firth. Walk beach or forest, visit a distillery, gallery or world-class Johnstons cashmere centre in Elgin. 45 minutes from Inverness Airport. email: jh.wyllie@btinternet.com Tel: 01343 831 114, or www.curlewcottage.co.uk

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→ **Orlando, Florida:** 4 bed 2 bath villa with private screened pool, cable TV and kitchen diner within 15 mins from Disney and golf. From £350 per week with discount for multiple weeks and bookings for late 2005. email: am@doctors.org.uk or Tel: 07801747815

→ **Puerto Banus, Costa del Sol:** Luxury large 2 bed/ 2 bath/2 balcony apartment in newly completed exclusive gated complex. 2 pools (indoor and outdoor), gym, sauna. Puerto Banus marina, beaches and nightlife 7 mins, Los Flamingos golf course 2 mins. Available from Jan 2006. email: ron_vickie@msn.com Tel 07980 608216

→ **Puerto Pollensa, Majorca:** 3 bedroomed house on small private residential development in quiet, leafy area. Sleeps 6. Small private garden, terrace and balconies; shared swimming pool. Convenient for beaches, mountains and birdwatching. All services provided, including cleaning and central heating. Tel: 01508 520987 or email jane@jmawer.fsnet.co.uk

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→ **Mazda MX-5:** 2001 Y, Dark blue, only 23,000 miles, FSH with Mazda, Good condition, 4 new tyres £8250 or offer Tel: 01895 422061 email: emmah@doctors.org.uk West London

→ **Skeleton:** Half skeleton in very good condition. £350 ono. Tel: 07961 173175. email: krishnadoc@hotmail.com

MISCELLANEOUS

→ **Christ's College, Finchley:** Keep in touch with medics from your old school through the Finchleian Medical Club (founded 1950) at the Annual Dinner, held at The Athenaeum Club, London. email: darryl.tant@ntlworld.com or Tel: 01582 763362

→ **Golf in the African Wild:** Pristine, malaria free, championship course with luxury bush lodges and local rules for antelope and giraffe. Also hotel with all sports amenities. 1 hour by air from Johannesburg Airport. Adjoins Kruger National Park and 4 mins from entrance gate. £35 p.p.p.n. B & B. email: valmal@batelco.com.bh

→ **India, Volunteers:** We invite all consultants, specialists, GPs and trainees in all specialities to work with us to help train local students and staff and provide services to the community in your chosen discipline from a few hours to as long as convenient for yourself in India. Tel. 01922 629842; fax: 01922 632942 or email: gwalior.hospital@care4free.net www.helpchildrenofindia.org or www.gwalior.hospital.care4free.net/volunteers.html

WANTED

Anthracite (coal) brickette. Just the one! Godfrey. (020) 8958 5113 cgmm@thersgb.net

The appeal court ruling on our end-of-life guidance

In February 2004 Mr Leslie Burke brought a judicial review of our guidance *Withholding and Withdrawing Life-Prolonging Treatments.*

Mr Burke has a progressive, degenerative brain disease that will eventually leave him unable to communicate his views and decisions. In the later stages of his condition it is expected that he will need various forms of life-prolonging treatment, including artificial nutrition and hydration (ANH).

He was concerned that discriminatory views about the quality-of-life of disabled people could mean that doctors caring for him at that time would not provide him with the same standard of treatment as other patients. Mr Burke argued that our guidance gave doctors the final say, so they could decide to leave him to die of starvation and dehydration in spite of his wish to receive ANH. As well as challenging the lawfulness of our guidance, Mr Burke sought court declarations concerning his right to receive ANH as he requests, while he is still competent and during the final stage of his illness.

In the original judgement Justice Munby found some limited aspects of our guidance unlawful and made declarations about Mr Burke's future treatment. In the statements leading up to the ruling, he ranged widely over the legal principles affecting treatment decisions in general, life-prolonging treatments and ANH, and the responsibilities of doctors and NHS bodies to provide treatment.

The GMC appealed against the judgement primarily because it seemed to make important changes to the law, which needed further testing and clarification. First, it made competent patients' requests for life-prolonging treatment 'in principle determinative' of the treatment they should be given. Second, it redefined the best interests test - used where a patient is incapacitated - so that the 'touchstone' for deciding best interests would be the 'intolerability' of providing or not providing the treatment. Third, it made it a legal requirement, in a range of situations, to seek the court's view before withdrawing a life-prolonging treatment.

The Appeal Court ruled that the guidance, as it stands, is lawful. Declarations were unnecessary to protect Mr Burke as the guidance does not permit doctors to act in the way he fears. Perhaps the most significant part of the judgement is the confirmation that:

"...In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it."

"Autonomy and the right to self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it."

The judges go on to explain the relationship between a doctor's duty of care and a patient's request for treatment.

'Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH...Where the competent patient makes it plain that he or she wishes to be kept alive by ANH...the patient's wish will merely underscore that duty.'

A number of important general points arose during this case. They are addressed in the GMC guidance, but are worth repeating here.

- Where a patient has an existing condition, it is essential to plan ahead with the patient, the healthcare team and the patient's family, so that if the patient later loses capacity to make their own choices about treatment, doctors are well informed about the patient's wishes.
- All patients are equally entitled to good standards of treatment and care. Doctors are under a duty not to discriminate, on grounds such as disability, in the choice of treatments or general standard of care provided to patients.
- Decisions about end-of-life care should be approached with a strong presumption in favour of prolonging life.
- Where a decision is made to withhold or withdraw a life-prolonging treatment, the patient's palliative care needs must be assessed and met appropriately. Patients who are dying must be afforded the same respect and standard of care as all other patients.

The GMC welcomes views on how to make the guidance better known, within the profession, amongst patients and by others involved in healthcare services. Email the standards & ethics directorate at **standards@gmc-uk.org** with your comments.

GP issued private prescriptions for controlled drugs for his wife

A general practitioner was found guilty of serious professional misconduct and his name was erased from the medical register after a Fitness to Practise panel found that over a 12-month period, following a previous appearance before the Professional Conduct Committee and a reprimand from them, he had continued to issue, in his wife's name, a significant number of private prescriptions for controlled drugs.

The panel found that the doctor had ignored GMC guidance advising doctors to avoid prescribing to close family members wherever possible, that he did not inform the general practitioner with whom his wife was registered of the relevant prescriptions and that he issued the prescriptions to his wife irrespective of any ongoing treatment that she might have been receiving from others.

The panel heard that the doctor had appeared before the Professional Conduct Committee the year before in relation to similar events. On the first occasion the doctor stated that he had stopped prescribing for his wife and the Professional Conduct Committee, having found him guilty of serious professional misconduct, placed no restrictions on his registration but reprimanded him. At the recent hearing, however, the panel found that, following the first hearing, the doctor had continued to issue private prescriptions to his wife.

The Panel heard evidence from the general practitioner with whom the doctor's wife was registered. The general practitioner expressed concern as he was unaware of the drugs prescribed privately to his patient by her husband, and commented on the potential risk of an adverse interaction with the medication that he prescribed, and the medication that his patient was obtaining privately from her husband. The panel also heard evidence from an expert witness who expressed similar concerns, and who was of the opinion that the doctor's conduct overall had been inappropriate, irresponsible and an abuse of his professional position.

It is good practice for doctors not to treat themselves or their families, except in emergency situations.

The GMC's publication *Good Medical Practice* sets out the guiding principles for providing a good standard of practice and care. It offers guidance on recognising and working within the limits of a doctor's professional competence, working with colleagues in the way that best serves patients' interests and on avoiding abusing one's position as a doctor. The panel noted that the GMC has also issued separate guidance, *Doctors should not treat themselves or their families* (July 1998), which states that it is good practice for doctors not to treat themselves or their families, except in emergency situations.

The panel considered the doctor's prescribing behaviour to be a matter of grave concern. It noted that he did not learn the lessons arising from his first appearance before the Professional Conduct Committee, and that he had immediately continued his previous unacceptable prescribing habits. In doing so he blatantly flouted the authority of his professional regulatory body. The panel was also concerned that the doctor had shown little insight into his actions. It determined that his conduct had fallen seriously short of the standards expected of a medical practitioner and seriously undermined the trust that the members of the public are entitled to place in the medical profession and its members.

In deciding what action to take against the doctor, the panel took into account submissions made by both parties, the advice of the legal assessor who was sitting with it and the GMC's *Indicative Sanctions Guidance*.

Good Medical Practice and the *Indicative Sanctions Guidance* can be read on the GMC website **www.gmc-uk.org**

PMETB *goes live*

The Postgraduate Medical and Education Training Board (PMETB) assumed its statutory powers on 30 September 2005.

It is the new body responsible for overseeing and promoting the development of postgraduate medical education and training for all specialties, including general practice, across the UK.

PMETB takes over the responsibilities of the Specialist Training Authority of the Medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

Bangalore Medical College

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GMC**today**

Your views matter!

If you wish to share your views about a particular matter, please contact the Editor, Jane Janaway at **gmctoday@gmc-uk.org**

Copy deadline for the December issue is 9 November 2005.

General Medical Council