The Medical (Professional Performance) Bill [Bill 83 of 1994/95]

Research Paper 95/44

31 March 1995

The Medical (Professional Performance) Bill, which would give new powers to the General Medical Council to deal with doctors' poor professional performance, was introduced into the Commons on 16 March 1995. Part I of this paper describes the current powers of the GMC and discusses how they could be amended. Part II of the paper looks at the provisions of the Bill and Part III considers the response to the Bill from political parties, the medical profession and patients' representatives.

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I Background

A. Introduction

The medical profession, like other professions in the field of health care, is essentially self-regulating. Only the medical regulatory body, the General Medical Council or GMC, is able to license doctors to practise in the UK by entering their names on its register, and only the GMC can strike a doctor's name off that register. However, the powers of the GMC are given to it by statute, and hence they are limited by the terms of that statute. This section of the paper will outline the current powers of the GMC, the criticisms which have been made of their limitations and the various proposals which have been put forward to meet these criticisms.

B. The powers of the General Medical Council

The GMC has had the statutory duty of regulating the medical profession since 1858 when the Medical Act 1858 was passed. It fulfils this duty by maintaining a register of qualified medical practitioners, by ensuring that those on its register are properly trained and conduct themselves in a professional and proper manner, and by taking disciplinary action where necessary. Although a statutory body, the GMC is independent of the Government: it receives no public funding, being financed by a levy on registered doctors; and rights of appeal given in statute against particular decisions of the GMC are heard by the Privy Council and not by the Secretary of State for Health. Its General Council consists of 54 elected members, 35 members appointed by universities and other specified bodies and up to 13 members nominated by Her Majesty on the advice of the Privy Council. While elected and appointed members all have medical qualifications, the majority of the nominated members must be lay people without such qualifications.

Since 1858, a number of Medical Acts have amended the powers and duties of the GMC and its current powers and responsibilities are consolidated in the *Medical Act 1983* (cap 54). As well as maintaining the register of qualified medical practitioners, the GMC also has powers over standards of medical practice through its powers to influence the content of medical education and to take disciplinary action where a doctor is deemed to be unfit to practise. These powers are exercised through a number of Committees which are prescribed in statute. The Education Committee has a general duty to determine what knowledge and skills should be taught in UK medical schools, to ensure that individual schools meet these standards and to determine the standards required to pass qualifying examinations. The Committee's role is therefore one of supervision; it does not involve itself directly with teaching or examining medical students. The remaining three Committees, however, the Health Committee, the Preliminary Proceedings Committee and the Professional Conduct Committee, have rather

different functions in that they are all involved in considering the cases of individual doctors which have been referred to the GMC. Referrals to the GMC can be made by individual patients, by NHS bodies or by colleagues, but it is important to note that the GMC will only act when a particular case is brought to its notice; it does not assume a proactive "policing" role of practitioners on its register.

1. Health procedures

The procedures for dealing with doctors whose fitness to practise is seriously impaired by a physical or mental condition are set out in rules made by the GMC, approved by the Privy Council and published as an appendix to *The General Medical Council Health Committee (Procedure) Rules Order of Council 1987*[1]. They include a number of stages, and in the majority of cases the Health Committee itself will not be involved. The aim of the procedures is both to protect patients from doctors whose state of health is affecting their professional competence and to rehabilitate sick doctors. The procedures therefore are designed to be supportive, rather than adversarial. Evidence referred to the GMC will first be considered by a preliminary screener, a member of the Council appointed for this purpose, who will decide whether the GMC's involvement is necessary. If this is the case, then the screener chooses at least two medical examiners (from panels nominated by professional bodies including the Royal Colleges and the British Medical Association) to examine the doctor in question. Where the medical examiners find that the doctor's fitness to practise is seriously impaired, the doctor will be asked to accept medical care and supervision and may, if the examiners recommend it, be requested to accept voluntary restrictions on practice. The recommendations could include requesting the doctor to refrain from practice altogether. If the doctor accepts these recommendations, the medical care will be arranged by a medical supervisor who will then report periodically to the screener. As the doctor makes progress, the screener may review the restrictions on practice, with the ultimate aim of the doctor returning to unrestricted practice without supervision.

The Health Committee will generally only become involved where a doctor refuses to co-operate in this way with medical examination, medical supervision or restrictions on practice. Cases such as these will be referred to the Committee which will hold hearings in private. If the Committee finds that the doctor's fitness to practise is seriously impaired by ill health, then it may suspend the doctor's registration for up to a year, or impose conditions on his or her registration for up to three years. The doctor has the right of appeal to the Privy Council against any decision of the Commmittee, but only on a point of law.

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[1]SI 1987/2174

2. Conduct procedures

The Preliminary Proceedings Committee and the Professional Conduct Committee deal with allegations of "serious professional misconduct" and with cases where a registered doctor has been convicted in the British Islands of a criminal offence. In the *Medical Act 1858* the phrase "infamous conduct in a professional respect" was used instead of "serious professional misconduct" but when the term was changed in the *Medical Act 1969*, the GMC made it clear that the phrases should have the same significance. "Infamous conduct in a professional respect" was defined in 1894 by Lord Justice Lopes in the following way:

> "If a medical man in the pursuit of his profession has done something with regard to it which will reasonably be regarded as disgraceful or dishonourable by the professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect."

A later definition was given by Lord Justice Scrutton in 1930 as:

> "Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession."[2]

Each case of alleged serious professional misconduct will be considered by the GMC on its merits and it is not possible to state with certainty how a particular action will be regarded. However, in its "Blue Book" on professional conduct, the GMC sets out five broad areas of behaviour which might well lead to disciplinary proceedings:

- "Neglect or disregard by doctors of their professional responsibilities to patients for their care and treatment
- Abuse of professional privileges or skills
- Personal behaviour: conduct derogatory to the reputation of the medical profession
- The advertising of doctors' services
- Comment on professional colleagues."[3]

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[2]definitions cited in GMC, "*Professional conduct and discipline: fitness to practise*", April 1992 (the "Blue Book")

[3]ibid, p.15

The procedures for dealing with allegations of serious professional misconduct are set out in rules made by the GMC, approved by the Privy Council and published as an appendix to the *General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988*[4]. If an allegation of serious professional misconduct is made against a doctor, the allegation is first scrutinised by the preliminary screener, a medical member of the GMC. Where the preliminary screener believes that conduct procedures are not appropriate and a lay member of the GMC agrees with this decision, then formal proceedings will not be continued. In all other cases, the doctor is informed of the allegations and invited to submit a written explanation and the case is passed to the Preliminary Proceedings Committee. Where a doctor has been convicted of a criminal offence, this will usually be referred directly to the Preliminary Proceedings Committee, rather than to the preliminary screener.

The Preliminary Proceedings Committee, having looked at the evidence, can decide either to refer the case on to the Professional Conduct Committee to be investigated further, to send a letter of warning or advice to the doctor, or to take no further action. Cases referred to the Professional Conduct Committee are subject to formal hearings, usually in public, and the procedures followed resemble those of a court of law: both the complainant and the doctor concerned will be legally represented and the hearings focus on specific charges. If, as a result of the hearings, the Committee concludes **both** that the allegations against the doctor are proven **and** that the allegations constitute serious professional misconduct, then it can decide to do nothing, postpone its decision, impose conditions on the doctor's registration, suspend the doctor's registration, or erase the doctor's name altogether from the register. Where a doctor has been found guilty of an offence in a criminal court, the Committee can, similarly, apply these penalties.

3. Limitations on the powers of the GMC

To date, unless it has been found that a doctor's fitness to practise has been seriously impaired by ill health, or unless a doctor has been found guilty of serious professional misconduct or convicted of a criminal offence, then the General Medical Council has no power to act against an individual practitioner. In particular, the GMC is not at present able to act either where a doctor's professional competence in general is shown to be inadequate, but no single act has been committed which could constitute "serious professional misconduct", or where a single act has indeed been committed, but is not judged to constitute "serious professional misconduct". While the NHS complaints procedures would be able to consider cases such as these, and take disciplinary action if appropriate, no NHS employing authority could prevent a doctor taking up employment elsewhere, either in the NHS or privately. Only the GMC has this universal power to restrict a doctor's practice or bar him or her from practice altogether.

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[4]SI 1988/2255, as amended

This lack of power to deal with cases not falling in the category of "serious professional misconduct" has given rise to increasing concern both among the public and the medical profession, and two distinctly different proposals have been made over the past decade as to how this gap could be closed. The first measure, put forward as a Private Members' Bill by Nigel Spearing MP in six different sessions of Parliament, proposed that there should be a lesser offence than "serious professional misconduct": that of behaving "in a manner which cannot be regarded as acceptable conduct". Doctors found guilty of this lesser offence could have their registration subject to conditions, in the way already provided for in the *Medical Act 1983* under the health and conduct procedures. One condition suggested by Mr. Spearing was that where doctors had been found guilty of "behaving in a manner which cannot be regarded as acceptable conduct" they could be required to return to a later hearing of the Professional Conduct Committee with references covering their conduct in the meanwhile[5].

Mr. Spearing illustrated his belief in the need for such an offence with the example of a child in his constituency who had died of meningitis after his GP had said he "couldn't be bothered" to examine him. Although the facts were found to be proven by the GMC, it was not felt that the charges amounted to serious professional misconduct. After the Bill was first presented in 1984, the GMC expressed its reservations, stating that although it appreciated that the intention was to improve the present arrangements, it did not believe that the Bill would achieve its aims. In particular, it felt that the Bill was unnecessary, as the Professional Conduct Committee already had the power to postpone finding whether a doctor was guilty of serious professional misconduct and could then require the doctor to attend a later hearing with details of referees able to report on the doctor's conduct in the intervening time. It was felt that the conditions on registration suggested by Mr. Spearing would add little to this existing power. The GMC also stated that the Bill would lead to practical difficulties, such as problems in maintaining a consistent distinction between the lesser and greater offences, and could lead to injustice because the lesser offence could lead to a more serious penalty than the greater offence. However, acknowledging the concerns underlying Mr. Spearing's Bill, the GMC issued more detailed guidance to doctors in the "Blue Book"[6] on their responsibilities for standards of medical care.

Although the GMC did not accept the need for a second, lesser, offence under the conduct procedures, it has become increasingly concerned about its inability to deal with questions of poor standards of performance, that is, complaints about poor professional performance *in general*, as opposed to complaints about a single incident. In 1992, it published a consultation paper, "*Proposals for new performance procedures*" which set out these concerns and proposed a new power for the GMC which would enable it to deal with these kinds of

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[5]GMC press notice, 6 June 1984

[6]see note 2

complaints. *The Medical (Professional Performance) Bill*[7] which had its First Reading on 16 March 1995 is based on the proposals made in this paper.

C. The GMC's proposals

In its consultation document, the GMC proposes that a third "jurisdiction" should be added to its two current "fitness to practise" procedures covering health and conduct. This third jurisdiction, "performance procedures", would be designed for:

> "those situations where a doctor's pattern of professional performance appears to be 'seriously deficient' - in other words, so blatantly poor that patients are potentially at risk, and action needs to be taken to resolve the deficiency and/or to restrict the doctor's freedom to practise."[8]

The paper emphasises that there should be an "equivalence of gravity" between this offence and those of *serious* professional misconduct and fitness to practise being *seriously* impaired by ill health. The procedures should therefore only be invoked when the doctor's performance was *seriously* deficient.

The document also explains why the GMC believes that it should become involved in dealing with under-performing doctors, rather than leaving this for NHS complaints procedures to deal with:

> "It is the GMC and not the NHS which is responsible for the registration of doctors. Action taken against a doctor by an NHS authority in one area will not necessarily prevent that doctor taking up practice in another area. Some doctors engage in a series of locum appointments which involve their employment by a succession of different health authorities and trusts, no one of which could have, or acquire, all the relevant evidence; nor, as a rule, are health authorities in a position to initiate formal disciplinary proceedings against locums. Moreover, NHS disciplinary procedures concern doctors currently employed or in contract with an NHS authority, whereas the GMC, and only the GMC, has jurisdiction nationally over all registered doctors in every type of medical practice, both within and outside the NHS."[9]

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[7]Bill 83 of 1994/95

[8]GMC, "*Proposals for new Performance Procedures: a consultation paper*", May 1992, p.8

[9]ibid., p.5

1. The aims of the procedures

The performance procedures proposed by the GMC aim to:

- protect the public from the potential dangers of seriously deficient performance
- be supportive and remedial, in that they aim to raise the standard of the doctor's performance, rather than exact penalties
- be wide-ranging, encompassing standards of professional knowledge, standards of professional skills and professional attitudes towards patients and colleagues
- be based on a local assessment, by a team including doctors in the same branch of practice as the doctor being assessed
- be thorough and fair, with doctors' performance being judged against predetermined and well-publicised standards
- cover doctors in all types of medical practice, including those working in private practice (who are not covered by NHS procedures) and by those working as locums.

The GMC document also emphasises what the procedures are **not** designed to do:

- They should not supercede existing conduct procedures.
- They will not form a lower tier of the conduct procedures, in the way suggested by Nigel Spearing's Bill discussed above.
- They will not be directly linked to medical audit procedures in the NHS.
- They are not aimed to attract a new category of complaint to the GMC; rather they will provide a way of dealing with many existing complaints concerning failures in professional performance.
- They will not be confrontational like the conduct procedures, but will rather resemble the health procedures, in which only cases where a doctor has refused help actually go before the formal Committee.
- They will not deal with contractual matters, which will continue to be considered in the first instance by the relevant employer.

2. The structure of the procedures

The proposed performance procedures would have four stages: screening, assessment of performance, remedial action and reassessment, and referral to the Professional Performance Committee.

In **stage I**, a preliminary medical screener would examine a complaint sent in to the GMC and decide whether it reached the appropriate threshold for either the conduct or performance procedures. If the screener decided that it was not appropriate for either procedure to be instigated, the papers would be referred to a lay screener before a final decision was taken. In such cases, and with the agreement of the lay screener, the complaint could either be passed to another, more appropriate authority, or an informal procedure could be followed in which the complaint would be sent to the doctor and the doctor's response passed on to the complainant.

In making their decision on the initial complaint, screeners would be able to obtain specialist advice, either from another member of the GMC or from the relevant Royal College and could also make other informal inquiries. If the problem appeared to be one related to health, the case could be passed at this stage to health screener; if it appeared to be an issue of serious professional misconduct, it would pass into the conduct procedures. If, however, the screener concluded that the performance procedures were appropriate for the particular case, then it would be passed to a specially appointed "performance screener" who would be responsible for directing any subsequent action.

In **Stage 2**, the performance screener would ask the doctor to undergo assessment. This assessment would usually be carried out by three assessors, of whom two would be doctors practising in the same specialty and one would be a lay assessor. Clear guidance would be given to assessors to ensure that there was consistency between cases, and advice on the standards of performance expected of doctors would be published in the GMC's "Blue Book". However, the scale and nature of the assessment would vary between cases, depending on the circumstances. The assessors would then prepare a report for the performance screener, having first discussed their findings with the doctor concerned. The doctor would also have the right to submit written evidence to the performance screener. Where the assessors found no evidence of serious problems with the doctor's performance, both doctor and complainant would be informed that the GMC would take no further action. If, however, serious deficiency was found, the performance screener would usually ask the doctor to follow the recommendations made by the assessors concerning limiting the doctor's practice or the need for some form of re-training. The performance screener would have the discretion, if the assessors agreed, to amend these recommendations on the basis of information submitted by the doctor. The complainant would be sent a broad outline of the outcome of the assessment and of the proposed further action.

If a doctor refused voluntarily to undergo assessment, the case would be referred to an "Assessment Referral Panel" which would consider the same documents as the performance screener and question the doctor on their refusal to be assessed. The Panel would then have the option either of deciding the doctor's refusal was justified (in which case, that would be the end of the matter), or of imposing the formal restriction on the doctor's registration that they should undergo performance assessment. The Panel would meet in private, but the doctor

would be entitled to legal representation and could appeal against the decision to the Privy Council on a point of law. If the doctor failed to comply with the Panel's requirement that they be assessed, then they would be referred to the Professional Performance Committee.

Stage 3 of the procedure would be concerned with counselling and retraining. The performance screener would arrange for appropriate retraining or advice to be provided, and would then arrange re-assessment by the same assessors who had seen the doctor in stage 2. Where performance was judged to be satisfactory, the case would end; where further re-training was required, this would be arranged. Although the length of time needed for improving the doctor's performance would necessarily vary from doctor to doctor, the stages of training, reassesment, further training, reassessment and so on would not be prolonged indefinitely. In cases where the doctor was failing to make the necessary progress or failing to co-operate with the retraining programme, the performance screener would have the power to refer the case to the Professional Performance Committee.

Finally, in **stage 4**, the Professional Performance Committee could consider the case. The GMC paper emphasises that this would be very much a "last resort" for doctors who refuse to cooperate with the earlier stages, or for those whose performance is so poor "as to be considered irremediable"[10]. As in the health procedures, very few of the doctors involved in the procedures should ever need to come before the Committee. The question of whether the hearings should be in public or private was one on which the GMC had received a great deal of comment; in the discussion document, a compromise was suggested whereby hearings would be held in private for a trial period of three to five years after which time the issue would be reviewed. While hearings were heard in private, a report of each case would be made publically available. Most of the evidence would be in the form of written material, and the aim of the hearing would be to decide on the basis of that evidence, with extra oral evidence from witnesses where necessary, whether the doctor's performance was indeed "seriously deficient". If it was decided that this was not the case, that would be an end to the matter. If, however, the Committee found that the performance was seriously deficient, then it could decide to impose conditions on the doctor's registration for up to a year, or to suspend their registration. A suspension could either be for a year, or for an indefinite period. As in proceedings under the Health Committee, the doctor would have the right of appeal to the Privy Council, but only on a point of law. The proposed power of suspending a doctor's registration indefinitely would be a new power for a Committee of the GMC, but was felt to be appropriate, as in a few cases of particularly poor performance retraining of much longer than 12 months might be necessary. In cases of indefinite suspension from the register, the doctor would have the right, after at least two years' suspension, to apply to the Committee for a return to the register, probably under conditions. The Committee would **not** have the power, open to the Professional Conduct Committee, to strike a doctor off the register altogether.

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[10]GMC, "*Proposals for new Performance Procedures: a consultation paper*", May 1992, p.34

The GMC estimates that between 100 and 150 cases a year might be referred to the preliminary screener under these procedures, and that it would take about 18 months from the passing of the necessary legislation before the first cases could be heard.

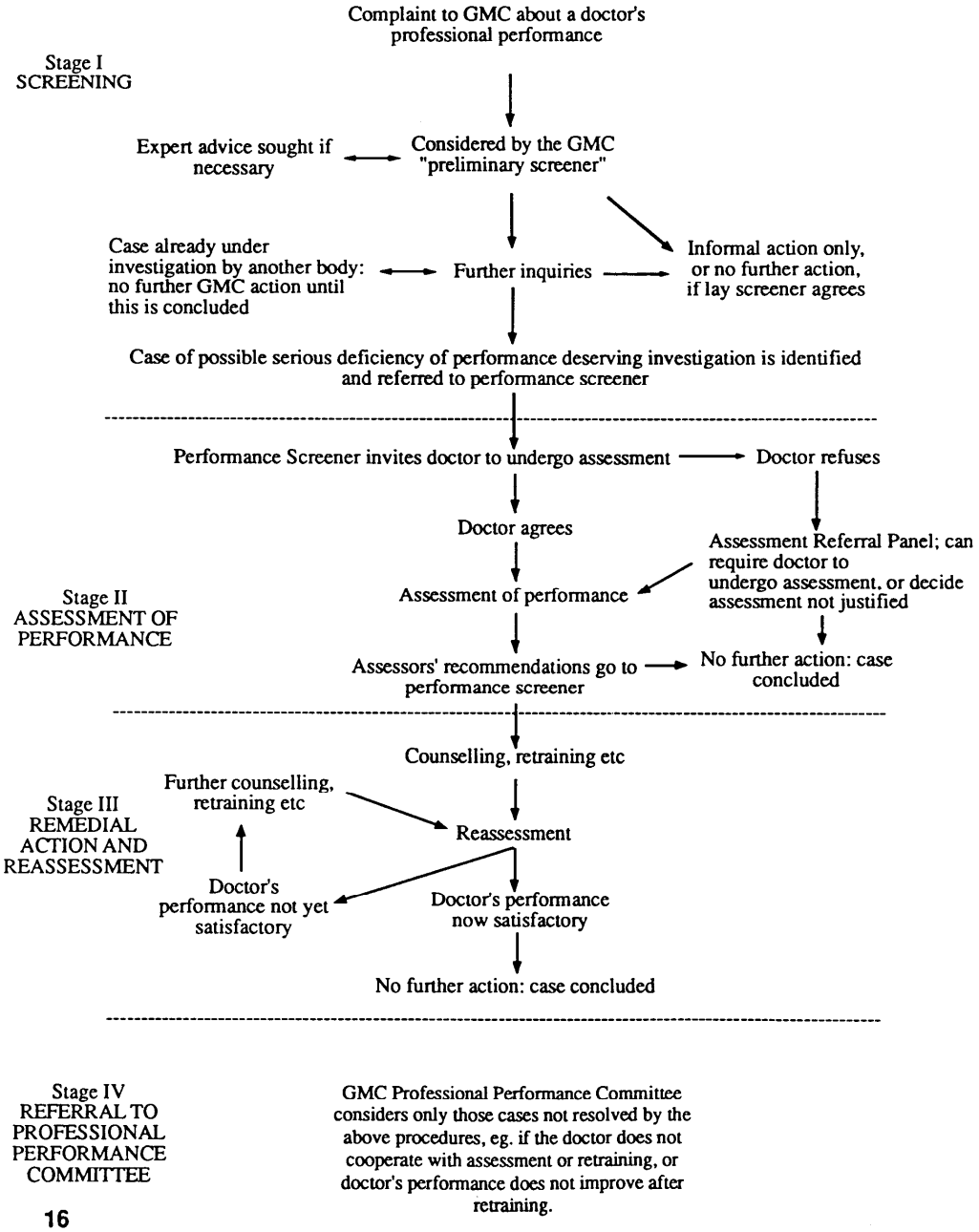
The following diagram sets out the main aspects of the four stages of the procedure:

I. HOW THE PERFORMANCE PROCEDURES WILL WORK

The principal features are summarised in the following flow chart, but not all of the detail is shown. The full procedure is explained in this part of the paper.

Figure 1

The proposed performance procedures



GMC, "*Professional conduct and discipline: finess to practise*", 1992

II The Bill

The *Medical (Professional Performance) Bill*[11] had its First Reading in the Commons on 16 March 1995. At the time of writing, the date for the Second Reading has not yet been set. Its main provisions are modelled on those set out in the GMC's consultation paper, although many of the finer details on how the process will work in practice are not actually specified in the primary legislation but will be set out later in Rules made by the GMC and approved by the Privy Council. This mirrors the way the procedures of the existing Health, Preliminary Proceedings and Professional Conduct Committees are determined.

Clause 1 of the Bill would insert a new section 36A after section 36 of the *Medical Act 1983* to introduce the procedures for dealing with poor performance. Where the performance of a practitioner was found to be "seriously deficient", the new section would give the "Committee on Professional Performance" the power either to suspend their registration for up to a year, or to impose conditions on their registration for up to three years [s.36A(1)]. If the latter penalty were imposed, but a practitioner failed to comply with the appropriate conditions, then the Committee would have the power to suspend the registration, again for a period of up to one year [s.36A(2)].

The period of suspension imposed by the Committee under this section could be extended for periods of up to one year at a time; alternatively when a period of suspension came to an end, the Committee could place conditions on the practitioner's registration for up to a further three years [s.36A(3)]. Likewise, where the Committee had imposed conditions on the practitioner's registration, it would have the power to extend this period of conditional registration for up to three years at a time, revoke the conditions, vary the conditions or suspend the practitioner's registration for up to one year [s.36A(6)]. This last subsection would contrast with the current health and conduct procedures in which each extension of a period of conditional registration can only be for one year at a time. (The GMC has also suggested amendments to the Medical Act 1983 at some point in the future, in order to allow for such three year extensions in the health and conduct procedures[12].)

The power of indefinite suspension would also be given to the Committee: this could be imposed where the practitioner's registration had already been suspended for at least two years and less than two months remained before the current period of suspension would expire [s.36A(4)]. In cases of indefinite suspension of registration, the practitioner would be able to request the Committee to review their case with a view to lifting the suspension, but only

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[11]Bill 83 of 1994/95

[12]GMC, *"Proposed changes to the Medical Act 1983 to improve the working of the GMC's conduct and health procedures: a consultation paper*", February 1994

after it had been in effect for at least two years and only once in every period of two years [s.36A(5)].

Where the Committee imposed conditions on registration or suspension of registration under this section, the Registrar of the GMC would have the duty of notifying the individual concerned and advising them of their right of appeal under section 40 of the 1983 Act. The same would apply if the suspension or conditional registration were to be extended, or if the conditions imposed on registration were to be varied [s.36A(7) & (8)].

The powers given by this section to the Committee on Professional Performance would apply not only to fully registered practitioners, but also to practitioners with provisional registration and limited registration [s.36A(10)]. Under the *Medical Act 1983* "provisional registration" is granted to those who possess the appropriate medical qualifications but have not yet obtained the necessary experience for full registration. "Limited registration" may be granted to doctors with overseas medical qualifications, permitting them to practise for a specified period in a specified post.

Clause 2 of the Bill would insert a new section 31A in the *Medical Act 1983*. This new section would give the GMC the power to make regulations both enabling a doctor to request voluntary erasure from the Register and setting out how the practitioner could later apply for their name to be restored. Any regulations made under this section would have to approved by the Privy Council before taking effect.

Clause 3 would give effect to the Schedule which sets out supplementary and consequential amendments.

Clause 4 would make the financial provisions for the Act.

Clause 5 would set out the commencement of the Act; different days could be specified for the various parts of the Act.

Clause 6 gives the long title and the extent: the Act would extend to Northern Ireland.

The **Schedule** would make a number of consequential amendments, mainly to the *Medical Act 1983*, to make provision for the new professional performance procedures set out in clause 1 of the Bill. In many cases, these involve granting the same, or similar, powers and

duties to the new Committees as those given to the existing Preliminary Proceedings, Professional Conduct and Health Committees.

Two new committees, the "Assessment Referral Committee" and the "Committee on Professional Performance" would be set up within the GMC, and the General Council of the GMC would be required to make rules providing for their constitution and governing their procedures [paragraphs 2, 9, 10 & 12]. Any such rules would have to be approved by the Privy Council before coming into force [para 11]. The rules would have to include certain provisions, stipulated in paragraph 13. For the Assessment Referral Commitee, these would include that before cases were brought before the Committee, they must first have been considered by a member of the General Council appointed for that purpose; that any party to the proceedings must have the right to be heard by the Committee and must be permitted to be legally represented; and that proceedings of the Committee must be held in private. For the Committee on Professional Performance, the rules to be made by the General Council would have to include the provisions that any party to the proceedings should have the right to be heard by the Committee and must be permitted to be legally represented. They should set out when the Committee's proceedings would be private and when public, with the proviso that they must be in public if the person whose professional performance they are considering requests this. The rules should also give an individual the right to have their performance considered by the Committee on Professional Performance, if their case has already been heard by the Assessment Referral Committee and their performance has been assessed in accordance with a direction of that Committee.

Further rule-making powers covering the assessment of professional performance would be given to the General Council of the GMC by paragraph 17 of the Schedule. Again, these rules would have to be approved by the Privy Council before coming into force. Such rules could give either of the new Committees or another specified person the power to direct a practitioner to undergo an assessment of their professional performance. This assessment would be carried out by an Assessment Panel whose constitution and procedures would be determined by rules made by the General Council. The General Council could also make rules to authorise the Committee on Professional Performance to suspend a practitioner's registration or impose conditions on it if he or she refused unreasonably to cooperate with the assessment. The Assessment Panels would be given a number of powers to assist them in their work, including the power to inspect records relating to the practitioner's professional practice and to take copies of such records. Anyone obstructing a Panel exercising these powers, without reasonable excuse, would be guilty of a criminal offence and liable to a fine not exceeding level 3 on the standard scale. A justice of the peace (or a sheriff in Scotland) could issue a warrant to permit premises (but not a dwelling house) to be searched, if they were satisfied that this was necessary for the Panel to carry out its assessment. Again, a person obstructing the terms of the warrant would be guilty of a criminal offence and liable for a fine not exceeding level 3 on the standard scale.

Both new Committees would be given the same powers as the Professional Conduct Committee and Health Committee to administer oaths; likewise, any party to the proceedings in the new Committees would be able to summon witnesses [para 14]. The same provisions covering legal assessors currently applying to the Preliminary Proceedings, Professional Conduct, and Health Committees would also apply to the new Committees: there should always be a legal assessor available during proceedings to advise the Committee on any points of law; and the Lord Chancellor (or, in Scotland, the Lord Advocate) would be given the power to make rules ensuring that when advice on any question of law was given, it must be in the presence of all parties to the proceedings, and that all parties should be informed if the Committee were to decide not to accept that legal advice [para 18]. The Committees would also be able to transfer cases to the Health Committee, where it appeared that the problem was actually one of ill health [para 16]. Such a provision already exists permitting cases being heard by the Professional Conduct Committee to be transferred to the Health Committee.

Practitioners would be given the right of appeal to Her Majesty in Council against a decision of the Committee on Professional Performance to suspend their registration, impose conditions on it or vary those conditions; however, such an appeal could only be on a point of law [para 6]. The same restriction already applies to appeals against decisions made by the Health Committee. The Committee on Professional Performance would have the same powers as those currently held by the Professional Conduct Committee and the Health Committee to order immediate suspension (rather than the suspension being delayed until the outcome of any appeal is known) in order to protect the public or where it is thought to be in the practitioner's best interest [paragraphs 5 & 21]. If the practitioner's registration were suspended, or conditions placed upon it, by the Committee on Professional Performance as a result of the practitioner refusing to cooperate with an assessment, the practitioner would have the right of appeal to the High Court (in England, Wales or Northern Ireland) or the Court of Session (in Scotland). Finally, there would be a provision to protect a practitioner's employment: where a doctor's registration was suspended by order of the Committee on Professional Performance, this would not lead automatically to their appointment being terminated, although they would be unable to perform their duties during the period of suspension [paras 8, 25, 26 & 27]. Again, this provision already exists for those whose registration is suspended under a direction from the Health Committee.

Financial effects of the Bill

The costs of administering the new Committees would be met by the General Medical Council who estimate that this may add between £8 and £10 a year to the annual retention fee paid by all registered practitioners. The costs to the NHS of retraining doctors to improve their professional performance is expected to be around £530,000 a year[13].

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[13]Explanatory and financial memorandum to the Bill

III Comment on the Bill

The Bill has met with a general welcome both from the opposition parties and the medical profession. Patients' groups, while seeing the move as a step in the right direction, have expressed reservations about the limitations of the new measures and how they will actually work in practice.

A. Political parties

Announcing the Bill during the debate on the Queen's Speech, the Health Secretary, Virginia. Bottomley stated:

> "I am pleased to be working with the medical profession in taking forward our proposed Medical Act (Amendment) Bill. The public rightly have confidence in the vast majority of our doctors, but there is regrettably also a very small number of doctors whose performance is deficient. The General Medical Council, the doctors' regulatory body, wants to improve the procedures which they have for dealing with that minority. There may be some, for example, who need further training before they can be allowed to continue to practise. This Bill will provide those necessary powers and the Government are glad to be able to support the GMC in that matter."[14]

Earlier in the same debate, Margaret Beckett, speaking for Labour, said that:

> "We are prepared in principle, for example, to give a fair wind to proposals to allow the General Medical Council, to address the service and care provided by general practitioners."[15]

For the Liberal Democrats, Alex Carlile, himself a lay member of the GMC, welcomed the Bill enthusiastically:

> "I start on a positive note by welcoming the commitment in the Gracious Speech to a Bill to introduce new procedures to enable the General Medical Council to deal with those doctors whose professional performance is found to be deficient ... The GMC wishes and is now to be allowed to deal with doctors whose performance falls below acceptable standards. The aim of the

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[14]HC Deb, 22 November 1994, cc 489-90

[15]HC Deb, 22 November 1994, c.479

> Council is universal good doctoring. With that extra shot in our locker, the council of which I am proud to be a member, will be able to deal with bad doctoring."[16]

B. The medical profession

The GMC and the BMA have both expressesd satisfaction that parliamentary time has been found for the Bill. Sir Robert Kilpatrick, President of the GMC, commented that:

> "We identified a gap in our powers and I am pleased that Parliament has been asked to fill this gap to enable us to do our job more effectively."[17]

The British Medical Association, similarly, stated:

> "The BMA is pleased that the Government has finally found parliamentary time for this Bill which the General Medical Council has been pursuing since 1992. It is a long overdue measure to ensure that the professionalism of doctors is maintained at the highest level at all times and has the overwhelming support of the medical profession. We are pleased that Mr. Malone has announced his intention to include new procedures designed to assess a doctor's knowledge, skills and attitudes in practice and provide remedial measures - rather than disciplinary one - to address any deficiences through retraining. We hope all this will be clearly stated in the legislation."[18]

C. Groups representing patients

Both the Patients' Association and the Association of Community Health Councils for England and Wales [ACHCEW] commented in detail on the GMC's consultation paper in 1992, as did the British Medical Association. Most of the concerns raised related to issues which are not covered by the primary legislation but which will be set out later in rules made by the GMC. However, in their response to the GMC's consultation procedure, ACHCEW were generally supportive of the proposals, although expressing some reservations:

> "The Association endorses the general thrust of the proposals as a response to the current lack of GMC procedures to deal with complaints relating to the general competence of doctors rather than instances of professional misconduct

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[16]HC Deb, 22 November 1994, cc 499-500

[17]GMC press notice, 16 March 1995

[18]British Medical Association press notice, 16 March 1995

> ... We would be extremely concerned if [the proposed procedures] were seen as a means of diverting cases which would previously have been considered by the GMC Professional Conduct Committee. It would also be very unsatisfactory if the development of performance review procedures were at the expense of thorough review of the operation of existing procedures for dealing with professional misconduct."[19]

ACHCEW also returned to the issue raised in Mr. Spearing's Private Members' Bill, expressing concern that the proposed amendments to the *Medical Act 1983* would do nothing to address "professional misconduct" which was less than "serious":

> "It would be possible, and, from ACHCEW's viewpoint, desirable to bring medical affairs into line with nursing affairs, where the UKCC [the nurses' regulatory body] has regard to professional misconduct, whether "serious" or otherwise."[20]

The Patients Association, in their response to the GMC, emphasised their belief that the success of the new procedures would depend very much on the way they were actually carried out:

> "In the view of the Patients Association the monitoring of the new procedures and the context in which they are carried out will be crucial to their success."[21]

When the Bill was published, Jean Robinson, a vice-president of the Patients Association and a former lay member of the GMC was more critical, with press reports quoting her as having said that:

> "[the procedures] would involve only cases judged on poorly defined criteria to be "serious", would operate entirely in private and would provide none of the rights to be represented or to seek judicial review which are enjoyed by patients bringing complaints of misconduct."[22]

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[19]ACHCEW's response to GMC's interim paper on performance review, 9 January 1992

[20]ibid

[21]Patients Association response to the GMC's consultation paper, 16 October 1992

[22]"Powers to tackle incompetent doctors 'will fail'", *The Independent*, 17 March 1995, p.6