

Peter Wilmshurst is known to many as a bastion of correctness. He has been involved with the GMC in a number of cases in which ethical probity or frank medical fraud has been in question. We invited him to describe the formal processes involved and share some of his experiences in this article. We emphasise that it represents the author's personal views. The GMC were approached as to whether they wished to respond to some of the points raised. Whilst they declined they were nevertheless happy for its contents to be published.

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The General Medical Council – a Personal View

For ten years in articles I have expressed concern that the medical profession is incapable of self-regulation.^{1,2} I have had meetings with the Chief Medical Officer and others in the Department of Health to express my concerns. I also have experience in the way that the General Medical Council (GMC) works and frequently fails to work. As I describe in this article, this experience arose because I was reported to the GMC and have reported other doctors to the GMC. I therefore have two differing perspectives of the way the GMC functions. My views differ greatly from the way the GMC attempts to portray itself in its press releases and in-house publications. I will provide some illustrative examples to support my arguments.

The website of the GMC (www.gmc-uk.org) maintains that its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. However, some of the general public, the medical profession, the media, parliament and senior judges, such as Dame Janet Smith who chaired the enquiry into the Shipman affair, seem to have little confidence in the ability of the GMC to fulfil its purpose.^{3,4,5}

The GMC was set up by Parliament (the Medical Act) in 1858. Its legal functions have changed little since then. They are to keep an up-to-date register of doctors practising in the United Kingdom, to foster good medical practice, to promote a high standard of medical education and to deal firmly and fairly with doctors whose fitness to practise is in doubt.

Justified criticisms have led to changes in the GMC in recent years. These included alterations in the size and composition of the Council in 2003, changes to the way that complaints against doctors were handled in 2004 and ongoing reforms to the registration process and introduction of revalidation. I believe that many of these changes are cosmetic.

It is important to remember that the purpose of the GMC is to protect patients, not doctors.

Other organisations such as the British Medical Association (BMA) represent and protect doctors, but many GMC members also have senior roles in organisations, such as the BMA, that represent doctors. In my opinion, this is just one of many conflicts of interest among GMC members.

The basic premise behind the working of the GMC is that self-regulation of doctors is in the public interest. The GMC has consistently been mainly composed of doctors, who were either elected by other doctors or appointed by organisations that were themselves composed entirely of doctors (such as royal colleges and medical schools). In my opinion, self-regulation is never in the public interest. By analogy, it is generally acknowledged that self-regulation of solicitors does not provide redress to members of the public, but serves to protect solicitors. We have an Independent Police Complaints Authority, because it is considered inappropriate for the police to investigate the behaviour of the police.

Businesses exist to benefit shareholders, not customers. Therefore, shareholders, not customers, elect or appoint the company executives. The executive board members of companies know that they must act in the best interests of those who appoint or elect them or they will be replaced. I believe that the obligation GMC members feel to those who elected or appointed them represents a conflict of interest that prevents the GMC from working for the good of the public. This is particularly the case when GMC members hope to be re-elected in the future. Election to the Council of the GMC has advantages. For example, when applying for Clinical Excellence Awards, one can list that one is leading at a National Level. In the past there were also very generous expense payments to GMC members. A member staying overnight in a hotel in London on GMC business could claim the full generous travel and overnight accommodation expense even though he / she got a cheaper ticket and stayed in a much less expensive hotel so that he / she spent much less than the

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maximum allowed. Locum expenses were paid. Some individual GMC members claimed over a hundred thousand pounds per year for 'expenses' for travel and accommodation.⁶ One could suggest that it was not in the interests of GMC members to lose these lucrative expenses by upsetting those who elect or appoint them. This only ended recently when public knowledge of this widespread and condoned practice eventually forced the GMC members to behave in a way more in line with normal accounting practices.

The old GMC had 104 members, of whom 75% were doctors. Most of these doctors were elected by other doctors, but a large proportion was appointed by medical academic institutions. The new GMC has 35 members, of whom 60% are doctors. The Privy Council, on the recommendation of the NHS Appointments Commission, appoints the lay members of the GMC. There are far fewer council members who are appointed by universities and royal colleges (one of each) but, in practice, the Council has co-opted another nine members of which seven are medical academics, including six professors who hold senior positions in medical schools and royal colleges. As a result, the changes have made little difference to the proportion of doctors or academics on the GMC.

One reason why it was felt that we need fewer GMC members is that until two years ago GMC members sat on the Professional Conduct Committee that adjudicated on the fitness of a doctor to practise. This caused concerns and raised the threat of legal challenge to the authority of the GMC. Firstly, there was no separation between the legislative and the judicial powers of the GMC (i.e. between those who made the rules and those who applied them). Secondly, there was unfairness in the process because there was no separation of investigation of a complaint, prosecution of the doctor and adjudication in the GMC hearing. In effect, the GMC had the roles of police investigator, prosecution council, judge and jury. Thirdly, there were problems in execution. Why should elected members of the GMC, with conflicts of interest and lacking legal training, make good adjudicators at hearings where the standard of proof ('beyond reasonable doubt') was that required in criminal legal cases? Appeal courts have ruled that adjudications by the Professional Conduct

Committee were frequently inconsistent, arbitrary and unjust.^{7,8,9} Since it was set up, the Council for Healthcare Regulatory Excellence has also appealed GMC decisions on grounds that findings were too lenient.^{10,11} This is a complaint that I and other critics have levelled at the GMC over many years.¹² Unfortunately, the GMC has responded to such criticisms, not as one might hope a proper judicial system would respond, but in the way that politicians do. When criticised for being too lenient, the GMC often responds by making the next few doctors who appear before it examples for the tabloid press. Then these decisions are appealed and eventually overturned by the Judicial Committee of the Privy Council.

I can provide many examples of inconsistency in the adjudications of the GMC. One case involved a professor who had falsely claimed an MD research qualification. He made the claim in job applications over a number of years. He put MD after his name in letters he sent and in the Good Doctor Guide. The professor was reported to the GMC in April 1999. In July 2001, the GMC decided that this dishonesty of the professor required no more than a private warning. I have searched the determinations of the GMC since 1980 and found seven doctors who have appeared before the Professional Conduct Committee between 1997 and 2003 for claiming qualifications that they had not been awarded and / or making fraudulent job applications. Three (Rashid Rhalife-Rahme in 1995, Seth Atardo in 1999 and Ashoka Prasad in 2000) were erased from the medical register. Three (Afolabi Ogunlesi in 1997, Abu Shafi in 2002 and Ashutosh Jain in 2003) were suspended from the Register. One (Sahmin Pandor in 2002) was reprimanded. Details of the adjudications in these hearings can be found on the GMC website. Some may ask why the Professional Conduct Committee publicly suspended or erased from the Medical Register a number of doctors, all of whom had African or Asian names, for claiming qualifications that they had not been awarded, but the GMC decided that in the case of a white British professor at a major academic institution only a private warning not to do it again was required. I have asked the Commission for Racial Equality to investigate whether verdicts of the GMC are racially biased.

The GMC hearings involving paediatric cardiac surgeons in Bristol also set an important precedent by finding that doctors have a responsibility to speak out if they have concerns about behaviour that might endanger patients. A doctor who fails to bring his concerns to attention may be guilty of serious professional misconduct and may be erased from the Medical Register. Thus, in a case that I reported to the GMC, a doctor was found guilty of serious professional misconduct for falsifying his research and the department head who supervised his research was also found guilty of serious professional misconduct for failing to deal properly with allegations that research fraud had occurred.² However, as I discovered in another case, this requirement of the GMC can place a doctor in a Catch-22 situation, because it is at variance with another GMC requirement.

As the chairman of the medical committee of a government recognised sport governing body, I wrote to the head of an institution to express concerns that doctors (including a number of consultants) employed by the institution appeared to have behaved unethically, and I requested that the head of the institution investigate the concerns of my committee. According to my understanding of the rules of the GMC, this was what I was required to do. However, rather than investigate my concerns, the institution reported me to the GMC for disparagement. This is one of the GMC's older rules that prohibits a doctor from saying things that might harm the reputation of another doctor. My concerns about the doctors were eventually upheld by the GMC, which issued them with warnings, but in the meantime I had eight months of correspondence and meetings with lawyers about my alleged disparagement. The Medical Defence Union could not understand how the GMC could require a doctor to raise, through formal channels, concerns that he has about other doctors yet put him at risk of investigation by the GMC for disparagement if he acted as the GMC required.

My experience of the GMC being used to try to silence a whistle blower is not unique. A more junior doctor, who had serious concerns, effectively had her medical career destroyed by the GMC. Members of the GMC made unfounded allegations that the doctor suffered from mental illness and

made it difficult for her to gain employment. The doctor sued the GMC and some GMC employees maintaining that the GMC broke its own rules and failed to follow its own procedures when blackening the reputation of a person raising legitimate concerns.¹³ The GMC had a court motion to 'Strike-out' the doctor's claims. In refusing the GMC's application, His Honour Judge Harris likened the GMC to a "Stalinist regime". After the hearing the GMC settled out of court.

Another case illustrates the problems of conflicts of interests and the strength of the 'old-boy' network within the GMC. I reported a doctor to the GMC for financial misconduct. Evidence presented at his hearing before the Professional Conduct Committee showed that the senior management of the hospital at which he worked had discovered his dishonesty and reached a severance agreement with him so that if he left without legal challenge, the hospital would destroy documents related to the fraud.¹⁴ The hospital also agreed a generous financial severance package and let him continue to use their private facilities until he was established elsewhere.^{15,16} The hospital did not report the doctor to either the police or the GMC. According to the medical director at the time, the Trust Board sanctioned the severance deal.¹⁴ The complaint against the doctor was upheld and the Professional Conduct Committee of the GMC suspended the doctor's registration, so clearly this was a complaint that warranted a report to the GMC. However, the chairman of the Professional Conduct Committee hearing had to stand down from the adjudication because he had been the medical director of the hospital at the time the deal to conceal the misconduct was agreed.¹⁷ Both the GMC's solicitors (Field, Fisher, Waterhouse) and I asked the GMC to take action against the GMC member who had failed to bring to the attention of the GMC concerns about a doctor that were subsequently proved to be serious. The GMC refused to take any action against its member. The GMC's rules require it to tell a complainant why it will not proceed against doctors if the GMC decides not to pursue a case. Contrary to its rules, the GMC refused to tell me why they were unwilling to take action against the GMC member. The GMC member subsequently returned to chairing hearings of the Professional Conduct Committee. Can one imagine a situation when a judge stood down from hearing a case because he had helped to conceal a crime and then was allowed to return to the bench?

Let us consider how the recent changes

at the GMC affect the way a complaint against a doctor is dealt with. The first thing to realise is that the GMC has done what politicians frequently do when the public loses confidence in an institution; make many cosmetic changes but leave the substance the same. For example, a complaint that is not frivolous and hence thrown out immediately by the registrar or assistant registrar, is now considered by two case examiners; one medical and one lay. It used to be considered by two screeners; one medical and one lay. If the complaint is serious enough it may be necessary for the Interim Orders Panel to immediately suspend a doctor's registration or impose conditions on working practices while the investigation is in progress. It used to be the Interim Orders Committee that performed the same function. After the doctor has provided his written version of events, he may have a private oral hearing before the Investigation Committee as a prelude to a public hearing before the Fitness to Practise Panel, which may erase or suspend the doctor from the Medical Register. In the past, after written submissions, the doctor may have had a private oral hearing before the Preliminary Proceeding Committee as a prelude to a public hearing before the Professional Conduct Committee, which could erase or suspend him. Apart from changes of name, there has been little change of substance. There is now formal separation of various stages of investigation and adjudication. From personal experience in the past, there was no formal separation of functions, but the level of internal communication at the GMC was poor, and this resulted in the same functional separation as exists now.

There are, however, some changes that seem appropriate. For example, the Fitness to Practise Committee now considers not only the conduct of a doctor but also how his health and performance may affect his fitness to practise. Previously health and performance were considered separately. Sometimes this separation at the GMC caused difficulties. For example, a doctor was suspended for one year by the GMC for research fraud.² It was pointed out to the GMC that they had failed to consider two other concerns that had been raised – namely allegations of financial dishonesty and concerns about clinical competence. The GMC responded that it could not do anything about those because the doctor was no longer on the Medical Register, as the GMC had suspended him from the Register. A year later when he was readmitted to the Register, I reminded the GMC of the unfinished business. The GMC then had to suspend him under Interim Orders before erasing him from the Register for

dishonesty and clinical incompetence spanning a decade. The whole process from initial complaint to erasure of a dishonest and incompetent doctor took four years, and the real tragedy was that for a decade before he was reported to the GMC his failings were common knowledge within some sections of the medical profession including academic institutions and a royal college that have a voice in the appointment of GMC members.²

In my opinion, the evidence suggests that the medical profession cannot be trusted to regulate itself. The GMC should be replaced with an independent medical complaints authority, like the Independent Police Complaints Authority. An advantage for doctors is that there would then be no need for doctors to pay large fees to the GMC. The Independent Police Complaints Authority protects the public and the public, through taxes, pays for its work. The body that replaces the GMC should be funded through taxation to protect the public. ■

Declaration of Conflicting Interests:

None declared.

References

1. Wilmschurst P. The code of silence. *Lancet* 1997;**349**:567-9.
2. Wilmschurst P. Institutional corruption in medicine. *BMJ* 2002;**325**:1232-5.
3. Smith R. The GMC: expediency before principle. *BMJ* 2005;**330**:1-2.
4. Richards T. Chairwoman of Shipman inquiry protests at lack of action. *BMJ* 2006;**332**:1111.
5. Elwyn G. Dame Janet's disappointments. *BMJ* 2006;**332**:1161.
6. Burke K. Trust chiefs cause flood of serious cases to GMC. *BMJ* 2002;**324**:1177.
7. Dyer C. Privy Council overturns GMC's erasure of psychiatrist. *BMJ* 2003;**326**:1417.
8. Dyer C. London GP cleared of serious professional misconduct. *BMJ* 2003;**326**:898.
9. Dyer C. Doctor wins battle against GMC's decision to strike him off. *BMJ* 200;**323**:1388.
10. Dyer C. GMC decision in Southall case challenged in High Court. *BMJ* 2005;**330**:556.
11. Samanta A, Samanta J. Referring GMC decisions to the High Court. *BMJ* 2005;**330**:103-4.
12. Wilmschurst P. The GMC is too lenient. *BMJ* 2002;**325**:397.
13. *R Pal v General Medical Council*, Sarah Bedwell, Catherine Green and Peter Lynn.
14. Dyer C. GMC hearing reveals how doctor won deal to have earlier inquiry documents destroyed. *BMJ* 2002;**325**:1189.
15. Notes of my discussions on 28th August 2003 with Detective Sergeant Cardow, Fraud Squad, Kilburn Police Station.
16. Notes of my discussions on 1st September 2003 with Sheila Webb, NHS Counter Fraud Service.
17. GMC conduct committee chairman stands down. *Hospital Doctor* 12th December 2002, page 4.