Revenue returns do not provide figures for expenses of a capital nature as they are not eligible for tax relief. We recognise that these returns include a figure for net capital allowances but that figure covers replacements or "depreciation" of capital invested in plant or equipment. It does not provide a return on the capital invested. We believe that the existing arrangements do not make sufficient allowance for the capital commitment in general practice. The arrangements for practice premises are under review, but the second component, the provision of "equipment," has to be met out of "net" income. We invite the Review Body to include a payment in general practitioner remuneration in recognition of the capital commitment which every GP has to make in providing "equipment" to enable him to practise.

Remuneration

The majority of the fees and allowances payable to GPs include both net remuneration and practice expenses. It is difficult or impossible to identify the net element in each item of service. However, the net income of a general practitioner with the average list of 2307 patients can be estimated for 1975-6 if notional deductions for practice expenses are made from fees and allowances on the same basis as is used for calculating net income for superannuation purposes. On this basis a practitioner in single-handed practice (not in a designated or rural area) would have received the following basic "net" remuneration for

Dr R Milsted, chairman of HJSC.

providing services during "normal hours" (defined in the Statement of Fees and Allowances as between 8 am and 7 pm on weekdays and between 8 am and 1 pm on Saturdays):

Basic practice allowance	£	1649
Standard capitation fee (1900)	2778	
Capitation fees for over 65s (320)	609	
Capitation fees for over 75s (87)	204	
Vocational training or first seniority allowance	580	
Public policy fees	121	
Maternity fees	351	
Temporary resident fees	126	
Total	£6418	

The number of consultations per patient per annum varies considerably. The General Household Survey in 1974 produced a figure of 3.7 per year. On that basis the net payment for each consultation was 75p. As at present

defined the "normal hours" of work of a GP amount to 60 hours per week, and his basic hourly rate of net pay was therefore £2.06. The same GP receives supplementary remuneration for being responsible for providing general medical services for 108 hours per week outside "normal hours." In 1975-6 the average GP would have received the following net payments (again using the same basis for calculation as above) for these services:

Supplementary practice allowance	£	323
Supplementary capitation fees	382	
Night visit fees	72	
Total	£777	

This represents an hourly rate of net pay of 14p. In the past general practitioners have accepted a total continuous service commitment, but in view of the inadequate sum paid for out-of-hours responsibility during these unsocial hours many are now calling for a limited contract. In other walks of life remuneration for unsocial hours is recognised far more generously. In 1970 the Health Departments advised that GPs with an on-call commitment to the hospital service should receive a minimum payment of one clinical assistant session per night, which at 1975-6 rates would give an annual income (for seven nights per week) of £4270—that is, £11.70 per night. GPs cannot accept that these levels of remuneration for out-of-hours work could possibly have been right as at 1 April 1975, and the Review Body is invited to reassess these payments as a separate exercise.

Medical Act 1978

JOHN MARKS

The original Medical Bill introduced into the House of Lords on 10 November 1977 was a slender piece of legislation that fell well short of the Merrison Committee's intentions.¹ The efforts of Lord Hunt of Fawley, supported by advice from the BMA, the GMC, and the Overseas Doctors Association, resulted in the House of Commons receiving an amended and much improved bill. So the 1978 Medical Act, when it received the Royal Assent on 5 May, translated most of what Merrison wanted into law.²

The Act deals with four major issues: the composition of the General Medical Council and its branch councils; professional conduct and fitness to practise; medical education; and the registration of overseas-trained doctors. It repeals reciprocal registration between the United Kingdom and some overseas countries and it replaces the unsatisfactory temporary registration system with limited registration.

Reformed GMC

Despite the length of the Act the future working arrangements of the GMC will depend on subsidiary legislation—Orders in

Council or rules made by the GMC and approved by the Privy Council. It is unlikely that there will be any changes for two years. After the "succession day" is set there will be three groups of members: those nominated by the Queen on the advice of the Privy Council; those appointed by universities and similar bodies; and those elected by the profession. The number of elected members must exceed the combined numbers of those appointed and nominated and all must be under 70. The Government has insisted that the four UK chief medical officers or their deputies must be eligible for nomination. As the Act says that a majority of the nominated members must not be doctors, there will have to be at least nine nominated members. There are no hard and fast rules about appointees. Each university which issues a medical qualification and all the royal colleges and their faculties could have one member. Orders in Council can provide for an appointing body to have more than one member or to combine with another body to appoint a single member between them, an unlikely occurrence. There will be four constituencies for electing members—England, the Channel Islands, and the Isle of Man; Wales; Scotland; and Northern Ireland. The present GMC is charged with preparing an

electoral scheme after consulting bodies representing medical practitioners—the BMA, for example—and the scheme must be approved by the Privy Council. All fully and provisionally registered doctors may stand for election and vote, as well as doctors who have had limited registration for three years during the four years preceding the election.

There will be branch councils for England, Wales, Scotland, and Northern Ireland, consisting of elected, appointed, and nominated members. Each shall appoint a registrar. The GMC may delegate functions to the branch councils but not the power to remove from the Register doctors whose entries are fraudulent, or the functions of the Professional Conduct, Health, and Preliminary Proceedings Committees.

Professional conduct and fitness to practise

For the first time the GMC will be allowed to advise the profession on standards of professional conduct and on medical ethics. The wording chosen strikes a balance between two viewpoints—those who fear that the GMC might stultify medical progress and those who

wish to protect doctors who, having accepted the council's advice, are accused of unprofessional conduct. On the appointed day the present disciplinary and penal cases committees will be abolished. There will be three new committees—on professional conduct, preliminary proceedings, and health. Rules approved by Orders in Council will determine their composition. Any member who sits on the Preliminary Proceedings Committee cannot serve on the other two when the same case is being considered.

The Preliminary Proceedings Committee will consider whether a case should be sent to either the Health Committee or the Professional Conduct Committee for a full inquiry. It can make an order for a doctor's interim suspension or conditional registration in order to protect the public. But the doctor must be given the opportunity to appear before the committee and be legally represented. The interim suspension must not exceed two months. If the Professional Conduct Committee finds that a registered practitioner has been found guilty of a criminal offence or is judged guilty of serious professional misconduct, it may erase him from the Register, suspend his registration, or impose conditions on it. Similarly, if the Health Committee decides that a doctor is judged "seriously impaired by reasons of his physical or mental condition," it may suspend his registration or make it conditional. Both committees can order immediate suspension in the interests of the public or of the doctor himself. Only in those circumstances is there a right of appeal to the courts, but, as at present, there will be a right of appeal to the Privy Council when a doctor is sentenced to erasure, suspension, or conditional registra-

tion, but appeals against decisions of the Health Committee are permitted only on questions of law.

Education Committee

The task of the Education Committee will be to promote high standards of medical education—a new concept—and to co-ordinate all stages of medical education. The GMC will decide the committee's composition, but the number of appointed members must exceed that of the elected and nominated members. The committee will have to decide the extent of the knowledge and skill required for granting a primary UK qualification. It must ensure that the teaching in UK universities is sufficient to equip students with such knowledge and skill. The committee will set the standard of proficiency required at qualifying examinations and the pattern of general clinical training for the profession. This is a far cry from "the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery, and midwifery," which is the present standard required for registration. The GMC will retain the task of testing knowledge of English.

There will be changes in the "experience required for full registration"—the pre-registration year. The Education Committee may appoint people to visit approved hospitals or institutions. The latter will report back on the extent to which the general clinical training given is sufficient, and they will have to take note of any unfavourable opinions.

Registration of overseas-qualified doctors

The largest section of the Act is devoted to the registration of overseas-trained doctors. Reciprocity will be abolished and the 1927 agreement with the Republic of Ireland terminated. Both the Republic of Ireland and Great Britain are now part of the EEC, which has rules governing the employment of doctors. Certain doctors may acquire full registration by virtue of holding a "recognised overseas qualification," which is granted outside the United Kingdom but is for the time being recognised by the GMC as furnishing a sufficient guarantee that the person has a standard training broadly comparable to a British primary qualification. Any such doctor may also register an additional qualification granted overseas. They must have the necessary knowledge of English and show the council that they are of good character and have done the equivalent of the pre-registration year. A few doctors who have recognised overseas qualifications may be eligible for provisional registration in the UK. This will enable them to do their pre-registration year and acquire full registration.

Another group of doctors who are eligible for full registration are those who wish to come to the UK temporarily to provide specialist medical services. No one can be on this Register for over 12 months, and the doctor must hold a recognised or acceptable overseas qualification, and show that he possesses special knowledge and skill in a particular branch of medicine.

The largest category of overseas doctors will, however, be eligible for limited registration. They must hold, or be eligible for, some acceptable (not "recognised") overseas qualifi-

cation and have been selected for employment in the UK or the Isle of Man as a medical practitioner in one or more of the hospitals or institutions approved by the council. They must show that they have the necessary knowledge of English, are of good character, and have appropriate knowledge and skills. This means that a doctor may have limited registration to do a series of jobs. At present he has to register temporarily for each separate post. But no one may have limited registration for more than five years. The council may determine the knowledge and skill required for any particular application for limited registration and may specify the period and the particular employment or type of employment. Doctors on the limited Register have the same responsibilities as the fully registered medical practitioner and are liable to disciplinary action, and they can also proceed to full registration. Having satisfied the Registrar that they are of good character, they can apply to the council to be fully registered.

The section dealing with overseas qualified doctors will be implemented in advance of the rest of the Act, which sets up a Review Board for Overseas Qualified Practitioners. The board will have a chairman and deputy chairman, who are not members of the council, appointed by the president. Until the succession day the membership of the board will include one doctor registered under part III of the 1956 Act—that is, an overseas doctor, nominated by the Queen on the advice of the Privy Council—and such other members as the council may prescribe, including at least one appointed and one elected member. After the succession day the members will include at least one elected, one appointed, and one overseas member who is on the full or limited Register. Overseas doctors whose applications for registration are refused by the council will have the right to appeal to the review board. The board will notify its opinion to the president, who can direct that the decision should be reversed.

There are numerous schedules to the Act dealing with the status, proceedings, and officers of the council; the establishment of committees; standing orders; and remuneration and allowances for members. The council's finances are not dealt with. In the House of Lords Lord Wells-Pestell made it clear the Government could contribute without further legislation.³ The profession will have to judge whether or not it wishes such a subvention. The profession's wish that the names of doctors charged appearing before the Professional Conduct Committee should be withheld until the results of the committee's deliberations were known was resisted by Mr Roland Moyle on behalf of the Government. But schedule 4 permits the council to hold private hearings in special cases.

This Act sets the scene for medical practice for the foreseeable future. Whether it works will depend on the council and those whom we, as practising doctors, elect to it.

References

- ¹ *Report of the Committee of Inquiry into the Regulation of the Medical Profession*, Cmd 6018. London, HMSO, 1975.
- ² *British Medical Journal*, 1978, **1**, 532.
- ³ *British Medical Journal*, 1977, **2**, 1458.

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In brief . . .

Junior staff: annual leave

The Joint Negotiating Committee has agreed an increase in annual leave from four to five weeks for registrars and senior house officers from 1 April 1978. During the current leave year, which ends on 31 October 1978, the annual leave entitlement will be increased pro rata. The information is set out in Health Circular (PC)(78)2. The Scottish circular is 1978(PCS)12.

Conference on HJS contract

There will be a one-day conference on the hospital junior staff contract and terms and conditions of service on Friday, 23 June. It will be open to junior staff, consultants, hospital administrators, personnel officers, and their staff; the cost (to include lunch and refreshments) will be £10-80 for BMA members and £27 for non-members. Applications, with remittance, should be made to European Study Conferences Limited, Kirby House, 31 High Street East, Uppingham, Rutland, Leics LE15 9PY.