The GMC: expediency before principle

Further difficult reforms are essential

The General Medical Council (GMC) has been submitted to a highly detailed forensic examination and found severely wanting. It has broken its contract with the public—to protect patients in exchange for the privilege of self regulation—and if it wants to survive it must now launch into a further round of reforms, even while those of the last few years are still being implemented.

The forensic examination has been conducted by Dame Janet Smith as part of her inquiry into the issues arising from the case of Harold Shipman, a general practitioner who murdered over 200 of his patients. Her fifth and final report, which is over 1000 pages long and makes 109 recommendations, examines the performance of bodies responsible for monitoring primary care and makes recommendations on how better to protect patients in the future.¹ I want to concentrate here on what Dame Janet said about the GMC.

Dame Janet's examination of the GMC has been complicated by her prey being on the move. But if the leaders of the council ever hoped that they could reassure her that she need not worry because reforms were under way they must have been seriously disappointed. She finds deficiencies not only in the "old" fitness to practise procedures but also in those introduced at the beginning of November 2004 and in the revalidation procedures to be introduced next April.

The GMC accepted when giving evidence to the inquiry that its "old" procedures "failed . . . to meet the reasonable expectations of patients and the public."¹ Nobody, I suggest, could dispute her analysis of the many defects of the "old" procedures. It might be argued that Dame Janet wasted her time and the public's money in the critique, but it was well worth doing not only for scholarly and legal completeness but also because many of the defects live on in the new procedures.

One fundamental problem is that whenever there is a trade off to be made between protecting the public and being fair to doctors the council has taken the side of doctors. "And thank goodness" will be the reaction of many *BMJ* readers, but if it is to command public and parliamentary confidence then the council must put patients and the public first. Another persistent problem is that the council has never agreed "standards, criteria, and thresholds" for serious professional misconduct. The result has been inconsistency in decision making. With the new procedures no standard is set for a finding of "impairment of fitness to practise."

Another problem has been that the GMC has been both prosecutor and judge, which conflicts with the Human Rights Act 1998. The GMC hopes to get round this problem by ensuring that the adjudication of fitness to practise will be made by people who are not members of the GMC. These people are, however, selected, trained, appraised, and if necessary fired by the council. This, argues Dame Janet, is insufficient separation of investigation and adjudication.

Dame Janet then turned her attention to revalidation and again found serious deficiencies. The law defines revalidation as "an evaluation of a medical practitioner's fitness to practise," but Dame Janet concludes that the arrangements that will begin next April will do no such thing. In order to be revalidated doctors will have to have been appraised and will need a "clinical governance certificate." But appraisal is a purely formative process that will not provide an evaluation of fitness to practise, and the certificate will simply state that nothing adverse is known. "A doctor will fail to be revalidated only if his or her performance is 'remarkably' poor," concludes Dame Janet.

Guaranteeing a doctor's fitness to practise is no simple business, and the original discussions around revalidation recognised the need for multiple methods of assessment. These, however, would be expensive, time consuming, and probably lead to many doctors failing to be revalidated—destroying professional lives, reducing the workforce, and creating a big need for retraining. Intense battles thus began, and the GMC retreated—to the point where revalidation will not do its job. Expediency, says Dame Janet, replaced principle.

Dame Janet reaches the same diagnosis on the GMC as its latest president, Sir Donald Irvine: the culture is wrong. It is reactive rather than proactive, prefers that doctors should be trusted rather than held accountable, places consensus before leadership, is driven by expediency and compromise, and in the last analysis will put fairness to doctors ahead of patient protection. Sir Donald, who was effectively forced out by the old guard, aspired to a culture "enthused with a spirit of openness, driven by the conviction that one's decisions must be routinely open to inspection and evaluation, like the openness that pervades science and scholarship."² Instead, he saw the GMC dominated by

"minimalists who still hankered after the old style of medicine...to do the least possible consistent with good appearances."³

The root of the reactionary culture, concludes Dame Janet, is the fact that elected members (all doctors) control the council. They see it as their job to represent doctors rather than regulate them. Dame Janet wants more medical members appointed rather than elected, something that is unlikely to please rank and file doctors who have rebelled in the past over "taxation without representation."

The old guard or minimalists are not entirely philosophically bankrupt. They can gain some comfort from another woman with an incisive mind, Onora O'Neill. In her Reith lectures she argued that attempts to replace trust with accountability may have gone too far: "The efforts to prevent the abuse of trust are gigantic, relentless, and expensive; their results are always less than perfect."⁴ There can never be so much transparency that trust is no longer necessary, and the challenge is to arrive at the correct balance of trust, transparency, and accountability.

The government will respond to Dame Janet's report early this year, but if the GMC wants to improve its performance—and survive—it will need to accept many of Dame Janet's proposals. This will mean overhauling fitness to practise procedures that have only just started, strengthening revalidation processes, and yet again changing its constitution. Does it have enough stomach for the battles ahead or will expediency again prevail? I doubt its ability to reform, but I'll be happy to be wrong.

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Competing interest: RS wrote a series of articles in the *BMJ* highly critical of the GMC in the late 1980s.

- 1 Shipman inquiry. *Safeguarding patients: lessons from the past—proposals for the future*. 5th report. www.the-shipman-inquiry.org.uk/fifthreport.asp (accessed 13 Dec 2004).
- 2 Friedson E. *Professionalism reborn: theory, prophecy, and policy*. Cambridge: Polity Press, 1994.
- 3 Irvine D. *The doctor's tale: professionalism and public trust*. London: Radcliffe, 2003.
- 4 O'Neill O. *A question of trust*. Cambridge: Cambridge University Press, 2002.

The changing face of familial colorectal cancer

Young patients with colorectal cancer should be assessed for genetic predispositions

Colorectal cancer is predominantly a disease of elderly people in the developed world. The annual incidence of more than 35 000 cases in the United Kingdom means that many people have at least one affected relative. Colorectal cancer in elderly relatives may be due to shared environmental exposure rather than a true genetic predisposition, although the risk of developing colorectal cancer rises with the number of relatives affected. Genetic factors may have a role in up to 30% of cases,¹ but only a small proportion (less than 5%) of colorectal cancers arise in families with strong histories in which tumours develop at a young age (less than 50 years) and represent truly high risk inherited predispositions. Even so, more than 1500 families per year need to be counselled and screened.

Most hereditary colorectal cancers are attributable to two recognised syndromes. Familial adenomatous polyposis usually has a clear phenotype, characterised by numerous (more than 100) adenomatous polyps in the large bowel by the second to third decades of life, which inevitably progress into cancers. This autosomal dominant condition, caused by *APC* gene mutations, has been a paradigm for the management of familial colorectal cancer. The use of registries, genetic testing, surveillance, and prophylactic surgery means that familial adenomatous polyposis now accounts for less than 0.5% of all new colorectal cancers, and patients' life expectancy is much improved.²

Hereditary non-polyposis colorectal cancer syndrome accounts for the bulk of familial colorectal cancer.³ The name is misleading as these colorectal cancers also arise from adenomas, but the degree of

Polyps in the colon

polyposis is less marked than in familial adenomatous polyposis. Hereditary non-polyposis colorectal cancer has a heterogeneous spectrum, and the phenotype is more difficult to define than in familial adenomatous polyposis.⁴ Some kindreds are predisposed to endometrial cancer, and other sites of cancer that may be associated include the stomach, ovaries, and urinary tract. We now know that hereditary non-polyposis colorectal cancer arises due to mutations in mismatch repair genes.⁵ Mismatch repair proteins correct insertion and deletion mutations that occur when DNA is copied before cell division. Such errors accumulate markedly in microsatellites, where the DNA sequence is repetitive, and hence, these cancers are said to display

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