Erasures and Suspensions from the General Medical Council (UK)

The patterns of erasure and suspension in the UK (GMC) have recently been analysed. The findings are of interest to all practising doctors. It would appear that certain groups of doctors, not least those working in the NHS, are more likely to be subject to the Council's scrutiny than others. A total of 796 doctors (0.35%) are either erased or suspended. In terms of gender, 96% are men and 14% are women; men are 4 times more likely to be affected.

Hospital specialists are only half as likely to be brought before the GMC when compared with GPs. Non-UK graduates have twice risk of that of UK graduates. Another important demographic finding is the length of time since qualification, the longer the time the greater the likelihood. The proportion with suspension or erasure for those qualified before 1985 is 0.4%, for those qualified 1995-2005 it is 0.23% and for those qualified after 2005 it is 0.09%. Doctors are 4 times more likely to face disciplinary problems after being qualified over 25 years. This may reflect increased levels of responsibility, large patient workloads, less time for their own professional development and failure to keep up to date.

Since its establishment in 1858 the GMC has overseen the professional conduct of doctors. For most of its existence it has focussed on misconduct. More recently clinical competence has come within its portfolio. The latter has caused confusion for practising physicians: Individuals understand misconduct so they have been taught how to behave by their parents, their teachers and during medical undergraduate ethics courses. Competence is a different matter. It is difficult to understand where it begins and where it ends. At what level has the bar been placed? If the standard is set too high few can be deemed competent and if it is set too low it serves no purpose. Also what is the doctor's fitness to practice? One commentator has defined it as capable equal to requirement. The judicious use of communication, knowledge, technical skills, clinical reasoning, emotional skill and reflection for the benefit of patients is another definition.

While such descriptions may be valid they are unhelpful when one is striving to perform competently at a medical emergency.

At a more fundamental level, competence is about being able to relate to people in distress and make them comfortable, having appropriate knowledge and skills, and possessing listening and communication skills. Competence describes what an individual is able to do in clinical practice. Performance describes what the individual actually does in clinical practice. How does one learn competency, how does one teach competency? The dimensions of medical competence include scientific knowledge, clinical examination, procedural skills, doctor-patient interaction and relations with colleagues.

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Doctors are facing serious challenges. Continuing professional development has become mandatory. Falling behind, getting out of date is not acceptable. All clinicians are going to need continued support and guidance from their professional bodies such as ICGP, RCPI, RCSI, Faculty of Radiology, on how best to achieve and maintain a competent standard.

JFA Murphy
Editor


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