The General Medical Council: Frame of reference or arbiter of morals?

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Many members of the public think of the General Medical Council (GMC) as the body which tries doctors: the doctors' law courts, as it were. And, except in the more sober of newspapers and news reports, the 'offences' which receive the most publicity are those concerning alleged improper relations between doctors and patients. Professor Sir Denis Hill, in the following paper, which he read in the spring of this year to the annual conference of the London Medical Group devoted to a discussion of human sexuality, chose to examine the whole function of the General Medical Council as a frame of moral reference for doctors. Judging allegations of professional misconduct by doctors is the function of the Council's Disciplinary Committee. Judging sexual misconduct forms only a small part of their work. The GMC's responsibility covers the whole notion of morals and morality as it concerns doctors in their professional work. Sir Denis Hill stresses the modern thinking that morality must be learned and that attitudes are always shifting as society alters its norms of what is moral conduct. That is not to say that all that was previously considered not to be moral has now become acceptable but rather that other concepts have entered the field of moral debate. Therefore the GMC must constantly review the frame of reference it offers to doctors and the public may be surprised to learn that that process is never static.

Sir Denis Hill in this paper is speaking personally and not as a member of the General Medical Council or of any of that body's special committees.

When I accepted your President's invitation to speak to the title 'The enforcement of morals' I did so with reluctance, and indeed some protest. My short answer to him was, of course, No, you can't enforce morals. Then I realized that many people think you can and there have been in the past very serious efforts, for example by the Catholic Church, to control sexual morals, to enforce conformity among its professionals. But then, of course, one must examine what one means.

Practical aspects to morality

There are two practical aspects to morality. How you behave and what you think and believe, and the two are not necessarily the same. It is easier to

control behaviour, provided the sanctions are severe enough. It is much more difficult to control thoughts and beliefs which together can be called attitudes. The Church found this out with Galileo. To be really effective, one must control both. I believe that the prospect of doing that is something we do not like at all.

Functions of the General Medical Council

DISCIPLINE OF DOCTORS

Discipline of the medical profession in relation to professional conduct is one of the three main functions of the General Medical Council (GMC) imposed on it by the Medical Act. Every year many hundreds of complaints about the behaviour of doctors are received from members of the public, from patients and from official bodies. Very few indeed are about their sexual behaviour. It is important to stress this fact, because whenever a doctor's sexual behaviour with a patient is such as to suggest that he has been guilty of serious professional misconduct, the case is given widespread publicity in the press. The public come to think that such cases are common, that they constitute a major part of the disciplinary work of the GMC. It is far otherwise, and I should like to set the record straight.

PROTECTION OF THE PUBLIC AND THE GOOD NAME OF DOCTORS

The job of the GMC is to protect the public and also the good name of the medical profession. It is concerned more than in former times with a doctor's fitness to practice. The official term 'serious professional misconduct' was substituted in the 1968 Medical Act for the older and rather savage term, 'infamous conduct in a professional respect' which had operated since 1858. But they mean much the same thing.

Legal definitions were given by Appeal Court Judges in 1894 and again in 1930. To quote Lord Justice Lopez, 'If a medical man in the pursuit of his profession has done something with respect to which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the GMC if that is shown, to say he has been guilty of infamous conduct in a professional respect'. Again, in 1930 by

Lord Justice Scrutton said: 'Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules written or unwritten governing the profession'.

From this you will see that it is for the medical profession itself to determine in any given case what is reasonably regarded as disgraceful or dishonourable behaviour and further, what are the rules, written or unwritten, governing the profession. In every case of complaint, however, there is the implicit assumption that some harm or damage to the patient has resulted or some harm to the profession.

SEXUAL MISCONDUCT BY DOCTORS

Obviously public opinion about sexual morality, including the opinion of the medical profession, has changed considerably over the years and no more rapidly than in recent times, yet the number of cases alleging sexual misconduct by doctors has not changed significantly. They remain, as I have said, a very small proportion.

To keep matters in perspective, I should remind you that there are over 75 000 doctors on the medical register. In 1973, of 120 cases in which complaints or convictions were considered by the Penal Cases Committee, only nine were in a sexual context. The Penal Cases Committee referred only four of these to the Disciplinary Committee. The largest groups, as in most years, were of doctors addicted to alcohol or drugs, 43 cases; doctors charged with or convicted of dishonesty or fraud, 27 cases; and doctors alleged to have disregarded their responsibilities to patients. It has been apparent to the GMC for many years that a significant proportion, about one in six, of the doctors against whom serious complaints are made, are mentally ill or mentally disordered in some way. This adds another and important dimension to the whole problem.

In 1973 there were four doctors, in 1971 five doctors charged before the Disciplinary Committee with sexual misconduct with their patients. In the periods 1950 to 1955 and 1960 to 1965, there were not more than three such cases in any one year. There were 10 in the first five-year period, 11 in the second and 14 in the period 1971-1975, but the excess in this latter period was due to 1971 and 1973. In 1974 and 1975 there was only one case each year. There is no evidence, therefore, of significant change in the referral rate.

You will be interested in what happened to these doctors. In the 1950s, seven of the 10 doctors' names were erased from the Register. In the 1960s eight of the 11 names were also erased. In the first five years of the 1970s, of 14 doctors the names of only two were erased, and a further seven were suspended for periods varying from six to 12 months. In four cases no penal action was taken. The new provision for suspension introduced by

amendment to the Medical Act in 1969 came as a welcome relief in the powers given to the GMC.

The moral responsibility of doctors to their patients

It would seem then that as far as sexual behaviour towards their patients is concerned, as well as in many other matters of a moral kind in their relationships with patients, the vast majority of the doctors of this country adhere to an unwritten code of conduct as a result of which very few complaints are made against them. This is a minimal fact. But what is the nature of this moral responsibility towards patients which the profession in general would seem to accept?

The earliest expression of it was of course in the Hippocratic writings, in the Hippocratic Oath, which until quite recent times many doctors on qualification in the western world were asked to swear. I will not read it all.

After the introduction, in which the new doctor affirms that he will treat his teacher as one of his family and share if need be his income with him, there are the following extracts:

'I will use treatment to help the sick according to my ability and judgment but never with a view to injury or wrongdoing.'

And later: 'In whatsoever houses I enter I will enter to help the sick and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free, and whatsoever I shall see or hear in the course of my profession, as well as outside my profession, in my intercourse with men, if it be what should not be published abroad I will never divulge, holding such things to be holy secrets.'

But a later Hippocratic writer, in the *Precepts*, after advising the doctor not to adopt luxurious headgear or elaborate perfume in order to obtain patients, says: 'Yet I do not forbid you trying to please, for it is not unworthy of a physician's dignity'.

The nature of morals and morality

I will now turn to the nature of morals and morality very briefly, not to the so-called science of morals which is ethics, which is not my subject. The word 'moral' is most often used as an adjective. We speak of moral courage, a moral victory, of accepting moral responsibility, of making moral decisions. We ask whether someone has a moral conscience.

Long ago in the days of faculty psychology it was believed that the human mind was made up of a series of independent mental faculties, powers or agencies which produced the various mental activities. These were innate, given by nature, and among them was a moral faculty, an inherent capacity to distinguish between right and wrong,

good and bad. Even in the latter half of the last century European psychiatry was encumbered with such ideas. Those patients who are today classified as personality deviants or psychopaths were explained as being the result of defects in the moral faculty, of being the result of hereditary degenerative disorders of the central nervous system affecting the hypothetical moral sense. Today it is accepted that personality characteristics which are reflected in most aspects of social conduct are learned.

Teaching morals and morality

If morals and morality must be learned, they can obviously be taught. What is being taught or learned leads to the acquisition of personal attitudes or beliefs as to what is right or wrong thinking, right or wrong behaviour. Behind moral behaviour there are usually moral attitudes and moral beliefs.

There are two ways of achieving this. One is by the inculcation of dogma and in the past traditional or conventional morality, including sexual morality, was taught in this way. It must be supported by the possibility of sanctions or threats such as the risk of hell fire or damnation or by the risk of disease or insanity, say due to promiscuity or masturbation, or at the very least the risk of social disapproval, of social ostracism. Dogmatized morality can only work if non-adherence to its precepts automatically induces in the miscreant a crippling sense of fear or guilt. Without them it is extremely weak.

The other way in which moral attitudes are learned is not through the operation of dogma and precept, external sanctions and punishment, but by a different sort of learning experience. In this, the individual comes to identify himself with the attitudes of those who teach him, not through fear but as a result of an involuntary and unconscious process of assimilation; a learning from example and a desire to emulate; to be at one with that which is felt to be good and worthwhile. Attitudes acquired in this way are altogether stronger and more lasting, but they must be buttressed by reason. They provide emotional security, but they can change and be lost if as a result of new experiences and new influences, the rational basis upon which an attitude is seen to be good can no longer be upheld.

Attitudes are therefore subject to changes in the social process and new cultural influences. Nevertheless, moral behaviour acquired through this process of identification is also subject to and maintained by sanctions. Now, however, the sanctions are internal and the potential guilt from infringement is as great, if not greater, than in the dogmatized variety. Now the individual blames himself and has to deal with his own moral conscience rather than fearing the blame and punishment from others. Morality learned by identification is thus much stronger and influences moral behaviour more effectively. Morality learned by acceptance of dogma

is as strong or weak as the probability of exposure and retribution for immoral behaviour is held to be.

Sociologists have in the past been interested in the ways different races and societies which have different cultural traditions inculcate moral attitudes and moral behaviour in their young.

The first studies were done just after the Second World War and it is not surprising that in the best known, in the behaviour of the Japanese, the Germans and the Americans were contrasted by the Americans¹. Their scientific validity is very doubtful, because at that time the influence of thinking about racial and cultural stereotypes was at its height. American attitudes to the Germans and the Japanese and beliefs about them which had been held before the war had radically changed as a result of it. It was found that the Japanese and the Germans inculcated moral behaviour by dogma, the Japanese using mockery, ridicule and social ostracism as punishments; the Germans, in the context of a strong family hierarchy with father acting as sergeant major inflicting physical punishment. For the Japanese, the greatest danger was losing the respect of others. Status was dependent upon saving face. For the Germans it was held that status depends upon accepting the moral dogma and status provided social power, particularly power over others.

When it came to the American view of American behaviour, it was admitted that at the start of life the growth of the moral self occurred in an authoritarian context, but the father's domination was softened by the role of the mother who combined discipline with indulgence. It was held, however, that very soon the sanctions and the guilt were internalized, the individual identifying with the attitudes appropriate to fit him for a life in which to compete for position and personal status in the social and economic struggle.

Moral attitudes subject to sanctions in society

I have given this example not because I believe that the actual differences found at the time were valid – and certainly they have no validity today – but because this type of work points to an undoubted fact. The members of every tribe, society or nation, if it is organized and reasonably stable, share in some degree common moral attitudes and beliefs, ideas about right and wrong, good and bad. Moral behaviour is continually subject to sanctions, external or internal, strong or weak. I believe that we still have strong moral attitudes. Murder, robbery, cruelty, are by common consent bad. Unlike certain tribes in New Guinea, we do not regard eating one another as good, but now a new set of moral attitudes, held by only a few in the past as being of the first rank, is now shared by increasing numbers of people.

Infringement of the rights of the individual,

inequality of opportunity and exploitation of one person by another are seen to be morally bad. Sexual behaviour, on the other hand, has now for many a changed moral value. In the last century, except for the aristocracy and the uneducated poor, sex was held to be somehow morally bad, although they had to put up with it. The pursuit of sexual gratification is now regarded by many, including many in our own profession, as a very desirable and healthy activity. Failure to obtain sexual gratification is regarded as a form of incompetence, perhaps due to learned inhibitions, ignorance or fear, often the expression of neurotic difficulties.

There are now in many places, both within and without the National Health Service, clinics where anorgasmic patients of either sex can receive treatment, including desensitization, exposure to films showing sexual behaviour and intercourse, encounter groups involving physical contact in which therapists take part, and recommended reading matter. Advice given by doctors and psychologists is freely available in magazines and journals on many bookstalls. The relationships between sexual behaviour and conventional and personal morality have become tenuous, but one still has to be specific and state the frame of reference. Incest is still universally regarded as bad. These changing attitudes to sexual behaviour are reflected in changes in the law relating to divorce and homosexuality.

What is the frame of reference governing the doctor's sexual morality?

I can now turn again to the medical profession and ask what is the frame of reference which governs or should govern the doctor's sexual morality and behaviour? We have to see this, I believe, in the sociological context of the medical profession as a tribe or social group distinct in certain ways from other tribes and other social groups within our larger society. The medical profession, like other professions, coheres because its members have common needs, both practical and financial, common objectives in their work and strive in common to maintain professional standards of behaviour and competence. They also share knowledge and skills denied to others and have a common tradition. It can also be said that its members share certain common ideals.

Without the respect and confidence of the public, the profession knows that its status will be destroyed. Insofar as principles of sexual behaviour in the context of their work are enforced or enforceable upon doctors, it can only be by the profession itself having a consensus. Such consensus is dependent upon the sharing of moral attitudes. It would seem from the experience of the GMC that moral attitudes about doctors' sexual behaviour are largely shared by the profession, and acted upon, but one cannot be sure.

The GMC Disciplinary Committee only operates in cases where the doctor is alleged to have far overstepped the threshold of what is acceptable. The GMC may only see the tip of the iceberg. There is no evidence in this country, but if recent reports from the United States are anything to go by, there is room for scepticism about consensus.

A recent survey², which was done by an anonymous questionnaire of 460 male doctors in California by a group at UCLA, was reported in 1976. Among the 460 male doctors were physicians, surgeons, obstetricians, general practitioners and psychiatrists.

The 460 male doctors were divided into the 'non-erotic', of whom there were 401, and the 'erotic' doctors, of whom there were 59. The non-erotic doctors had denied sexual contact with their patients; the erotic group had admitted to it. It was found that the freer a doctor was with non-erotic physical contact, the more likely he was to engage in erotic contact with them.

The attitudes displayed in the questionnaires were of interest in distinguishing the two groups to the question, 'Under what circumstances might erotic contact with a patient be beneficial?' The majority of non-erotic doctors were unanimous that erotic contact was never beneficial and condemned such behaviour by such remarks as 'represent ignorance or exploitation on the part of the doctor' or 'any doctor who can't control his emotions is unqualified' or 'any doctor who does needs therapy' or 'very sick behaviour' or 'destroys relationship' or 'unethical, unthinkable; any doctor who does it is treating himself, not his patients' and finally 'might be all right for psychiatrists but never for doctors'.

The erotic group of 59 doctors who were in a one to five minority showed different attitudes, although many also condemned erotic practice, but among them were those who deplored it for different reasons, such as, 'might lose licence to practice' or 'it happens but it is an error' or 'it is an occupational hazard' and lastly 'I told the patient not to return afterwards'. It would seem that some of them, while accepting a sexual morality which they regarded as a dogma, did not really identify with it and did not in fact abide by it. Those erotic doctors who had a different morality appeared to be identified with it and gave reasons such as the following: 'It demonstrates the doctor's effectiveness to his patient'; 'It supports and reinforces the patient's sexual appeal'; 'Stimulating the clitoris helps the patient relax' but there was evidence of conflict and doubt and moral attitudes which were decidedly grey. 'It is all right when the patient is over 21' or 'with consent - but not in the office' or 'when intercourse is made part of the therapy' and finally, 'it is all right for teaching purposes'.

The reports which have appeared in the American literature make it clear that certainly in one state a proportion of doctors in all branches of clinical

practice engage in sexual behaviour including sexual intercourse with their patients – nearly 7 per cent in the series quoted. Some regard this as in no way immoral but indeed beneficial and therapeutic. The great majority, however, express deeply hostile and critical attitudes to such behaviour. A small proportion accept the dogmatized morality but in fact engage in erotic practice. A study reported in 1972³, also in California, showed that 25 per cent of first-year medical students felt that sexual intercourse with a patient could be appropriate under 'the right circumstances' or 'if the doctor was genuine and authentic'.

In Britain, for some time there have been suggestions that the General Medical Council has not always shown consistency in its responses when doctors have been reported on charges of sexual misconduct. There are, as I pointed out, few such cases, but they always receive damaging publicity.

The GMC, because of its judicial function, cannot offer individual doctors advice as to how they should behave in particular circumstances. The Council could not respond, for example, to the doctor who wrote asking, 'Will it be all right to sleep with Miss X if I cross her off my list?' The GMC, nevertheless, issues a pamphlet⁴ on professional conduct and discipline in which there are some guidelines. About sexual behaviour, in the 1976 edition, it says this:

'The Council has always taken a serious view of a doctor who abuses his professional position in order to further an improper association or to commit adultery with a person with whom he stands in a professional relationship.'

This statement has remained unchanged for some years. The GMC periodically reviews this pamphlet. In the near future the Council will again consider these matters and what advice can be offered, and particularly about sexual misconduct and the vexed question of what is an 'improper association'. I cannot tell you how they will decide to modify this brief statement I have quoted, but I do know that for some time discussions have gone on with the relevant professional organizations and a great deal of thought is being given to the matter.

I would like to express a personal hope about the direction towards which we may move our frame of reference. I said earlier that incest is still a universal taboo. The strictest frame of reference I know is that of the psychoanalyst and the psychiatrist who see an exact emotional parallel between the doctor-patient relationship and the parent-child relationship. If you believe this, erotic seduction or sexual intercourse can only be seen as no less incestuous

between doctor and patient than they are between parent and child. The child is trusting of the parent and the patient is no less so of the doctor.

But the frame of reference can surely be broadened to make it accommodate contemporary general morality without necessarily accepting the Freudian theory. It is based upon the undoubted fact that the doctor is in a privileged position in relation to his patients and their families. He is trusted by them and he is only able to help his patients and their families if he does nothing to undermine that trust. He must expect that his patients and their families will depend upon him, sometimes lean on him and some patients will become overtly emotionally attached to him. The sex of the doctor is immaterial.

The emotional relationship between the patient and the doctor may become intense. When the patient is or has been seriously ill the doctor may become idealized and this idealization can be immensely gratifying to the doctor, feeding his own narcissistic needs and his sense of power. Moreover, the doctor has intimate physical contact with the patient. This is a situation which he can easily exploit, not only erotically or sexually but also in other ways. But if he does, he will sooner or later lose that trust and the patient or the family will feel they have been damaged. Indeed they will have been.

I think the key word is probably 'exploit' and sexual exploitation is one way in which a doctor can gravely misuse his privileged professional position.

Finally, I would like to think that as we move forward into what Theodore Fox called the 'greater medical profession', there will be a common frame of reference for us all, a shared moral responsibility. Many different professionals now accept responsibility for the care and treatment of patients; having their own skills, much responsibility is delegated to them. They have the same privileges as a doctor and share with him the same emotional risks. Perhaps they can also share his moral responsibility.

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