February 2000

GPC

General Practitioners Committee

The work of the LMC in England and Wales

Guidance for LMCs

BMA

The work of the local medical committee in England and Wales
(as at 8 September 1999)

A Background

1 1911-1999
LMC representation of principals providing general medical services ("GMS") in England and Wales.

2 From 1 September 1999 (England only at present)
LMC representation of all general practitioners.

B The formal establishment of an LMC

C Functions and duties

D Administration of the contract

1. General medical services regulations
2. Terms of service
3. Pharmaceutical regulations
4. Statement of fees and allowances (the "Red Book")
5. The complaints procedure
6. Professional conduct

E Representation of the profession

1. Consultation
2. Under regulations
3. Health department circulars
4. Other health service bodies
5. Medico-political functions
6. General Practitioners Committee
7. General Medical Services Defence Fund
8. Statutory levy
9. Voluntary levy

F Conclusion

A Background

1. 1911-1999
LMC representation of principals providing general medical services ("GMS" in England and Wales

1.1 When the National Insurance Bill was first introduced in 1911 no provision was made for general practitioners to participate in the administration of the new state health insurance scheme. But the British Medical Association was determined that the profession should have a voice in its day-to-day running. It therefore ensured that locally elected committees of general practitioners (local medical committees - "LMCs") were given statutory recognition in the 1911 National Insurance Act as the representative voice of the 'panel' doctors.

1.2 The 1911 Act required the Local Insurance Committee (the forerunner of the NHS Executive Council, the family practitioner committee, family health services authorities and latterly health authorities) to consult all general practitioners participating in the health insurance scheme on a wide range of matters via the LMC. After the LMCs had been set up, a national committee was established within the BMA to represent the interests of 'panel' doctors in negotiations with government. This national committee, the Insurance Acts Committee (the forerunner of the General Medical Services Committee - latterly the General Practitioners Committee "GPC"), was recognised by government as the authoritative voice of general practitioners.

1.3 It was not surprising that the Liberal government agreed to these arrangements for representing general practitioners. The success of the 1911 health insurance scheme depended on the willing co-operation of a large number of independent practitioners. The profession supported the introduction of a state medical scheme but was strongly opposed to a salaried service; it recognised that the loss of the independent contractor status would undermine the freedom of doctors to practice without state interference, and ultimately put patient care at risk. General practitioners feared that government would seek to direct them in their day-to-day treatment of patients. This commitment to the contractor status remains a guiding principle of the GPC. Indeed, had it not been for the tenacity of its forerunner - the National Insurance Acts Committee - on this crucial issue, general practitioners could have been drawn into a salaried service (as were their hospital colleagues in 1948). The well tested and proven value of the contract for service with the local insurance committees led to the preservation and extension of this type of contract when the NHS was established in 1948. The Local Insurance Committees - the original predecessors of the HAs - knew that this contract worked successfully and were active in ensuring that it was preserved in the new NHS structure.

Background - from 1 September 1999 (England only at present)
LMC representation of all general practitioners

Notwithstanding the ever increasing number of deputies who assist principals in general medical practice, and notwithstanding the introduction of a different contract for providing personal medical services ("PMS") or PMS+ pursuant to the provisions of the National Health Service (Primary Care Act) 1997 the potential for practitioners working as deputies or providing PMS or PMS+ to be recognised as practitioners who were represented by an LMC did not come about until 1 September 1999 when section 11 of the Health Act 1999 was brought into force.

At present section 11 of the Health Act 1999 has only been brought into force in England. As at 26 January 2000 details of the relevant Commencement Order to be made by the Welsh Assembly were still awaited.

B. The formal establishment of an LMC

2.1 Section 11 of the Health Act 1999 the statutory recognition and functions of the LMCs are defined in sections 44 and 45 of the National Health Service Act 1977 as variously amended and in their amended form these sections are as follows; the sections in bold being those affecting general practitioners:-

"44- (A1) A health authority may recognise a committee formed for their area which they are satisfied is representative of-

(a) the medical practitioners providing general medical services or general ophthalmic services in that area;

(b) those medical practitioners and the deputy medical practitioners for that area; or

(c) the medical practitioners mentioned in-

(i) paragraph (a) above; or

(ii) paragraph (b) above,

and the section 28C medical practitioners for that area,

and any committee so recognised shall be called the local medical committee for the area.

44 (B1) A health authority may recognise a committee formed for their area which they are satisfied is representative of-

(a) the dental practitioners providing general dental services in that area;

(b) those dental practitioners and the deputy dental practitioners for that are; or

(c) the dental practitioners mentioned in-

(i) paragraph (a) above; or

(ii) paragraph (b) above,

and the section 28C dental practitioners for that area,

and any committee so recognised shall be called the local dental committee for that area."

44 (1) Where a health authority is satisfied that a committee formed for their area is representative - of the ophthalmic opticians providing general ophthalmic services or of the persons providing pharmaceutical services in that area the health authority may recognise that committee; and any committee so recognised shall be called the local optical committee or the local pharmaceutical committee, as the case may be, for the area concerned.

44 (2) Any such committee may with the approval of the health authority delegate any of their functions, with or without restrictions or conditions, to subcommittees composed of members of that committee.

44 (3) For the purposes of this section and section 45 below, a person who meets the condition in subsection 4) below-

(a) is a deputy medical practitioner for the area of a health authority if he is a medical practitioner who assists a medical practitioner providing general

medical services in that area in the provision of those services but is not himself on a list;

(b) is a section 28C medical practitioner for the area of a health authority if he is a medical practitioner who provides or performs personal medical services in accordance with arrangements made under section 28C above by the health authority (whether with himself or another);

(c) is a deputy dental practitioner for the area of a health authority if he is a dental practitioner who assists a dental practitioner providing general dental services in that area in the provision of those services but is not himself on a list;

(d) is a section 28C dental practitioner for the area of a health authority if he is a dental practitioner who provides or performs personal dental services in accordance with arrangements made under section 28C above by the health authority (whether with himself or another).

(4) The condition referred to in subsection 3) above is that the person concerned has notified the health authority that he wishes to be represented under this section by the appropriate committee for their area (and has not notified them that he wishes to cease to be so represented).

(5) For the purposes of subsection (3) above-

(a) a person is to be treated as assisting a medical practitioner or dental practitioner **in the provision of services if he is employed by that practitioner for that purpose or if he acts as his deputy in providing those services; and**

(b) "list" has the same meaning as in section 46 below."

45 (1) Regulations may require health authorities-

(a) in the exercise of their functions under this part of this Act to consult committees recognised by them under section 44 above,

(b) in the exercise of any of their functions which relate to arrangements under section 28C above to consult committees recognised by them under section 44(A1)(c) or (B1)(c) above,

on such occasions and to such extent as may be prescribed.

(1A) The power conferred by subsection (1) above is without prejudice to any other power to require a health authority to consult any committee recognised under section 44 above.

(1B) Committees recognised under section 44 above shall exercise such other functions as may be prescribed.

(1C) A committee recognised for an area under subsection (A1)(b) or (c) or (B1)(b) or (c) **of section 44 above shall, in respect of each year, determine the amount of its administrative expenses for that year attributable-**

(a) in the case of a committee recognised under subsection (A1)(b) or (c)(ii) of that section, to the deputy medical practitioners for the area;

(b) in the case of a committee recognised under subsection (A1)(c) of that section, to the section 28C medical practitioners for the area;

(c) in the case of a committee recognised under subsection (B1)(b) or (c)(ii) of that section, to the deputy dental practitioners for the area;

(d) in the case of a committee recognised under subsection (B1)(c) of that section, to the section 28C dental practitioners for the area.

(2) The health authority may, on the request of any committee recognised under section 44 for their area, allot to that committee such sums for defraying the committee's administrative expenses as may be determined by the health authority

(3) Any sums so allotted shall be out of the moneys available to the health authority for the remuneration of persons of whom the committee is so recognised is representative and who provide general medical services, general dental services, general ophthalmic services or pharmaceutical services, as the case may be, **under this part of the Act. The amount of any such sums shall be deducted from the remuneration of those persons in such a manner as may be determined by the health authority**.

(4) Where a committee has made a determination under subsection (1C) above, it shall apportion the amount so determined among the deputy medical practitioners, section 28C medical practitioners, deputy dental practitioners, or section 28C dental practitioners, **as the case may be, for the area and each such practitioner shall pay in accordance with the committee's directions the amount so apportioned to him.**

(5) References in this section to administrative expenses of a committee include references to travelling and subsistence allowances payable to its members; but the reference in subsection (2) above to a committee's administrative expenses does not include so much of the committee's administrative expenses as are determined under subsection (1C) above to be attributable to any practitioners mentioned in that subsection."

Thus all general practitioners may now be represented by their LMC whether they be principals providing GMS (the position before the Health Act 1999) or deputies assisting such principals together with practitioners providing or performing PMS.

C. Functions and duties

3.1 The many functions and duties of the LMC that derive from its statutory recognition insofar as the provision of GMS is concerned may be subdivided into two groupings ie those concerned with:-

(1) The administration of the GMS contract
(2) The representation of general practitioners as a whole.

3.2 However, in addition LMCs perform many other services for their constituents, the pattern of which is established by local 'custom and practice'. These functions are outlined further in the section on non-statutory functions of LMCs. They include the handling of ethical problems and the representation of GPs in relation with bodies and organisations outside the NHS and maintaining the standing of general practice in the media and among the public generally. Many LMCs have established close ties with MPs, local councillors, community health councils, and with other professional groups such as nurses, health visitors and social workers.

Over the years many LMCs have co-opted representatives of GP registrars and have found this to be beneficial. Co-option enables newer members of the profession to become familiar with the work of the LMC at the beginning of their careers in general practice. LMCs may also have contacts with pressure groups. The LMC has a major role in the provision of primary care. As an

independent body with statutory functions, it occupies a unique position of influence within the NHS.

D. Administration of the contract

Whilst HAs are required by statute to consult LMCs on many issues; detailed in the regulations governing the provision of NHS GMS, the terms of service for general practitioners and the statement of fees and allowances (see below). There are not as yet any comparable requirements to consult LMCs concerning the provision of personal medical services under part I of the 1977 Act. Accordingly sections 1, 2 and 4 below should be read as applying only to the provision of GMS; such matters in the main being dealt with separately in pilot scheme contracts. The LMC also plays an important part in the complaints procedure and investigation of matters relating to professional conduct.

1. General medical services regulations
2. Terms of service
3. Pharmaceutical regulations
4. Statement of fees and allows (the "Red Book")
5. The complaints procedure
6. Professional conduct

-oOo-

1. General medical services regulations

There are many references to LMCs in the NHS (GMS) Regulations 1992 (as amended), requiring that they be consulted:-

Reg	5A(3)(b)	in connection with the conditions to be imposed on an applicant to the medical list 6(4) prior to the removal of a doctor's name from the list who has personally never provided services or has ceased to provide services for the past six months.
	11(1)	prior to the HA making a reference and report to the medical practices committee (MPC).
	12(8)(a)	to receive a copy of the MPC's determination and statement regarding the adequacy of general medical services in the locality.
	13(3)	in connection with the selection of conditions of practice to be imposed on any doctor who fills a particular vacancy.
	15(3)	prior to the HA making an application to vary or revoke a decision of the MPC.
	17(4)	prior to the HA making a decision as to whether an additional doctor should be a member of a partnership or a sole practitioner.
	18	this regulation lists the instances in which the LMC must be consulted - namely:-

	on a reference under Regulation 11(1) on a selection of a condition of practice under Regulation 13(3) on an application for variation or revocation under Regulation 15 on a decision about an additional doctor under Regulation 17(4) on setting or agreeing criteria under Regulation 18A(4), 18B(2) or (7) or 18D(5), or on nominating or approving an additional doctor pursuant to Regulation 18A, 18B or 18C further in certain cases the health authority must give LMCs written notice of decisions and the reasons therefore.
18I(11)	by the HA with regard to the appointment of a replacement doctor
24(7)	on a proposed block transfer of excess patients from one doctor's list to another.
25(2)	about temporary arrangements for carrying on a practice.
25(5)	where it appears that a doctor is incapable of providing general medical services because of his physical or mental condition. After such consultation with the LMC the HA may require a doctor to be medically examined.
25(6)	where it appears that a doctor's terms of service are not being adequately carried out in order to make arrangements for the temporary provision of general medical services for that doctor's patients which may consist of or include the appointment of one or more doctors to undertake the treatment of such patients.
25(7)	where it appears that a doctor is fit to resume practice.
25(8)	where a doctor is required to be medically examined before the HA vary or terminate any arrangements made under 25(6) above.
25(9)	to appoint a doctor to undertake the medical examination, to consider the report of the examination and to report in writing to the HA as to the doctor's fitness to carry out his obligations under the terms of service.
30(6)	where the HA considers medical advice necessary, on the application by a doctor for inclusion on the obstetric list.
30(8)	where the health authority is considering whether to grant an application in a case where the applicant satisfies none of the criteria to be considered before inclusion in an obstetric list.
34A(2)	on the Secretary of State's determination in relation to payments to suspended doctors.
34B(3)	on the establishment of GMS local development schemes.

36 on the determination of whether a substance is a drug.

37(3) to receive a copy of the medical list and amendments.

2. Terms of service

There are many references to LMCs in the terms of service (as amended), to be consulted:-

para 11(2) about the termination of the provision of maternity medical services.

18A(9) on a proposed refusal by the HA to grant approval of an out of hours arrangement.

18B(3) on a proposed withdrawal by the HA of its approval of an out of hours arrangement.

22(6) before the HA requests evidence that an organisation providing deputy doctors is continuing to provide a service which is adequate and appropriate.

22(8) before a HA issues a remedial notice (where, in a response to a request for evidence, the HA continues to have reasonable grounds for believing that an organisation providing deputy doctors is not providing a service which is adequate and appropriate).

24(2) before refusing or withdrawing consent to employ an assistant.

27(b) to inspect practice and premises.

50(2) where the HA requests information relating to the referral of patients to other services during the period of an annual report

3. Pharmaceutical services regulations

Reg 5(1)(b) & (2)(b)
notification of applications.

7(1)(a)(iv) & (2)(b)
notification of decisions.

9(3),(5) & (13)
determination of controlled locality.

10(1)(c) & (2)
appeals on applications to the (Committee) relating to rurality of an area.

12(1)(a), 2(a), (11)(a)(ii) & (a)(v)
determination by HA of application to provide pharmaceutical services

13(11) appeals to the Secretary of State from decision of HA on applications to provide pharmaceutical services.

22(3) to receive a copy of the medical and pharmaceutical lists and amendments.

25(b) transitional provisions concerning appeals made prior to 1 April 1992

4. Statement of fees and allowances (the "Red Book")

Up to and including SFA 22 there are in excess of 50 references to LMCs:-

para 14.8 to be consulted on difficulty in agreeing with a doctor the percentage of his patients resident in a designated area.

18.2/4 to be consulted on any proportionate reduction in the assistant's allowance.

24.11 to be consulted on the payment of a higher night visit fee where a doctor makes a series of claims for more than one consultation during the course of a single visit to the same institution or address

24.13 to be consulted about the dates on which night visit fees will be paid by the HA

30.12 to be consulted on how to apply criteria in relation to the HA approving a chronic disease management programme

30.16 to be consulted on payment arrangements for health promotion or CDM programme activities

31.7 to be consulted on the sharing of the maternity medical services fee.

31.19 to be consulted when HA disputes a claim for a full care fee.

32.10 to be consulted on advance payment for the treatment of temporary residents.

33.10 to be consulted on payment of a special fee for emergency treatment.

33.14 to be consulted on the recovery of an emergency treatment fee from the list of another practitioner.

40.2 to be consulted by the HA with regard to qualification for the sustained quality allowance

41.9 to be consulted if the HA is proposing to adjust 'reckonable income' for the purposes of calculating the type 1 allowance.

41.11 to be consulted on withholding payment of an initial practice allowance if the HA is not satisfied that a genuine endeavour is being made to build up the practice.

41.12 to be consulted by the HA on whether an area should be designated a special area for purposes of payment of IPA type 2.

43.7 to be consulted on the determination of a doctor's main surgery for calculation of rural practice units.

44.3 [Schedule (3)1] dispensing doctors and provision of oxygen equipment.

44.10 to be consulted on a doctor's application to receive special payments for the supply of drugs and appliances.

44.9 to be consulted on a doctor's application to be exempted from the discount scale.

48.10 to be consulted on variation of the normal requirements for payment of locum allowance during sickness , particularly in rural areas.

48.17 to be consulted on assessment of hours for full-time locum allowance.

50.8 to be consulted on consideration of normal hours for locum during prolonged study leave.

51.2 to be consulted on acceptance of premises for rent and rates.

51.3(i) to be consulted where a HA believes that a doctor's proposed move to new premises or enlargement of existing premises does not offer significant improvement so as to justify an increase in reimbursement.

51.3(ii) to be consulted with regard to the drawing up of a HA plan for the satisfactory delivery of general medical services to meet future needs.

51.3(v) to be consulted with regard to new branch surgeries.

51.7 to be consulted with regard to the proper use of surgery premises for the delivery of general medical services.

51.12 to be consulted before the abatement or cessation of reimbursement of rent and rates.

51.25 to be consulted on apportionment of gross value for rating in combined premises.

51.34 visits to premises in connection with rent and rates.

52.4 in connection with the employment of a salaried doctor employed by a practitioner under the practice staff scheme, the LMC's approval must be sought on the contract of employment.

57.5 to be consulted on limitations to practices for payment of a workforce flexibility allowance.

57.6(ii) to be consulted with regard to the partnership agreement in force belonging to practitioners applying for the workforce flexibility allowance.

57.6(iii) to be consulted on the criteria against which programmes aimed at improving the delivery of patient care are to be approved

57.7 to be consulted as to withholding payment of the workforce flexibility allowance.

57.14 to be consulted on the criteria for approval of collaborative arrangements.

57.15 to be consulted on the withholding of the collaborative working allowance.

59.1 to be consulted on all or part of certain expenses incurred after 1st April 1995 in delivering general medical services outside normal hours.

59.5 to be consulted with regard to individual funding applications to the HA for the provision of out of hours services by individual doctors

59.6 to be granted access to sufficient information by the HA in order to ensure that out of hours development moneys are used exclusively for such purposes

60.3 to be consulted by the HA about whether a mainland practitioner experiences the same degree of "isolation" as an island practitioner for the purpose of entitlement to locum payments

60.4 to be consulted by the HA with regard to applications for permanent or temporary locum payments from isolated rural GPs

60.9 to be consulted by the HA with regard to permanent locum payments to isolated rural GPs and any notice period to govern the termination of such arrangements

60.10 to be consulted by the HA where local circumstances may warrant a variation in the agreed term for payment of permanent locum payments

60.11 to be consulted by the HA with regard to applications for temporary locum payments to isolated rural GPs

60.12 to be consulted by the HA with regard to the notice period to govern the agreed term for payment of temporary locum payments to isolated rural GPs

60.13 to be consulted by the HA where local circumstances may warrant a variation in the duration of temporary locum payments

62.2 to be consulted on entitlement of doctors providing maternity medical services only to direct payments under the rent and rates and ancillary staff schemes.

62.3 for doctors providing maternity medical services only, to be consulted about whether it is necessary for the purposes of additional payments during sickness or confinement for a practice to engage a locum or deputy from outside the practice who is on, or qualified to be on, the obstetric list.

63.2 to be consulted when the eligibility of a restricted principal with a limited list for payments under the rent and rates and practice staff schemes is in doubt.

68.2 to be consulted on the entitlement of contraceptive service only doctors on their entitlement to direct payments under the rent and rates and ancillary staff schemes.

68.3 to be consulted on the entitlement of contraceptive service only doctors, to additional payments during sickness.

69.2 to be consulted when the eligibility of a principal providing child health surveillance services only for payments under the rent and rates and practice staff schemes is in doubt.

69.3 for doctors providing child health surveillance only, to be consulted about whether it is necessary for the purposes of additional payments during sickness for a practice to engage a locum or deputy on the CHS list.

70.2 to be considered where the eligibility of a principal providing minor surgery only for payments under the rent and rates and practice staff scheme is in doubt.

75.1 to be consulted on dates for payment of 'other' fees and allowances.

The complaints procedure

Each HA has a medical discipline committee consisting of a chairman appointed by the HA who must be a solicitor or barrister and no more than six other persons, no more than three of whom are appointed by the HA and no more than three professionals by the HA from a list of nominees provided by the LMC.

There are several references to LMCs in the NHS (Service Committees and Tribunal) Regulations 1992 (as amended), which relate to the service committee procedure:-

Reg 8 (3)	LMC consulted in relation to the determination of the HA as to the imposition of special limits on the number of persons for whom a doctor, to whom a report of a discipline committee relates, may undertake to provide treatment
9(3)	LMC consulted on recommendation that limit be imposed on list size because doctor unable to give adequate treatment.
15(3)(b)	nomination to HA professional committee to investigate excessive prescribing.
15(11)(e)	member or officer of the LMC is entitled to be present as an observer.
16 and 17	procedures on financial withholding and investigating record keeping.
Schedule 2, para 1	constitution of medical discipline committee:
Schedule 2, para 4(5)	LMC consulted where the appointment of the Chairman of the discipline committee is referred to the Secretary of State

Schedule 4, para 4(2) and (4) — LMC given by the HA not less than 21 days notice of the date, time and place of a disciplinary hearing and not less than 7 days before the hearing LMC supplied with the HAs statement of case, practitioner's response, comments, observations and correspondence.

Schedule 2, para 5(5) — acceptability of replacement medical service committee chairman and joint services committee chairman.

Schedule 4 para 5(2)(c) — member or officer of the LMC who is authorised by the LMC is entitled to be present as an observer [and, under Schedule 44(2), entitled to receive all the documents in each case].

Schedule 7
(1) procedures under regulation 18
(2) failure of HA and LMC to agree.

6. **Professional conduct**

Whereas the medical discipline committee investigates complaints which allege a breach of the terms of service, when certain aspects of professional conduct are called into question, other investigations are undertaken by the LMC itself and the HA is not involved apart from being the referring body in some cases. These functions are prescribed in the following paragraphs of the National Health Service (Service Committees and Tribunal) Regulations 1992 (as amended):

Reg 16 certification - failure to exercise reasonable care in the issue of certificates.

17 record keeping - so far as the recording of clinical data is concerned.

18 decisions as to treatment for which fees may be charged.

20 to consider any complaint made to the LMC by any doctors against a doctor practising in the locality of the committee involving any question of the efficiency of the general medical services.

On each matter (except under 20) the secretary of state refers a specific case to the LMC to investigate and report; in practice, the reference to the LMC comes first from the HA. The LMC responds to the HA which then informs the Department of Health. In effect the HA is acting as the agent of the secretary of state. Any subsequent action by the secretary of state takes into account the LMC's views. On several of these matters, if the secretary of state is not satisfied with the findings of the LMC, he may appoint other persons to determine the case in question.

Note: The last revision of January 1997 has been updated to incorporate the amendments to the terms of service for doctors made by the National Health Service (General Medical Services) Amendment Regulations 1997 SI 1997/730.

E. Representation of the profession

5.1 The LMC is consulted by the HA and other bodies when the views of general practice as a whole are required. The LMC also has a vital part to play in the conference of LMCs, and the LMC/GPC medico-political axis. It elects representatives to both the conference of LMCs and the GPC.

5.2 Consistent with the extended recognition of LMCs under section 11 of the Health Act 1999 is the statutory requirement under the Primary Care Trusts (Consultation on Establishment, Dissolution and Transfer of Staff) Regulations 1999 (wef 8 September 1999) that before the secretary of state may make a primary care trust order the health authority within whose area the PCT is to be established must, inter alia, consult the LMC for the area of the health authority (regulation 2(2)(d)). Similarly there is a consultation requirement prior to an amendment of a PCT order or the dissolution of a PCT. Following each consultation the health authority must, inter alia, send the results of the consultation to the secretary of state and provide copies of any written responses to the consultation

5.3 **Health department circulars**

The Department, under the auspices of the 'NHS management executive' issues advice or notifications to HAs in the form of health circulars. Some introduce amendments to the terms of service, others give revised guidance to HAs on how to implement existing arrangements and others notify LMCs of remuneration changes and changes to the "Red Book". Normally circulars are issued to health authorities with the requirement that relevant ones are copied to LMCs.

In addition to advice, guidance and the notification of changes circulars can also require HAs to consult with LMCs.

5.4 **Other health service bodies**

The LMC serves as the point of reference for other NHS bodies seeking the views of general practitioners. A perusal of LMC minutes (the GPC secretariat is sent copies of the minutes of many LMCs) shows that this is a large component of LMCs' work. Although general practitioners are no longer represented, as of right, on HAs, some continue to serve and some serve on unit management groups (UMGs) as unit medical representatives (UMRs). In some areas, LMCs appoint doctors to serve on regional medical advisory committees, regional advisory subcommittees in general practice, purchasing advisory bodies, district medical advisory committees (where these are established), and alternatively, on variously named district medical liaison committees and district medical executive committees, regional general practice subcommittees for postgraduate medical education, together with various ad hoc committees, and working groups both clinical and administrative at regional, district and unit levels. The LMC is consulted when general practitioners are appointed to many of these offices and posts, and it plays an active part in advising health authorities on a wide range of policy matters. In short, it has a continuing dialogue with other branches of the NHS. The LMC also becomes involved in many other issues affecting general practitioners locally: examples include, clinical assistant posts, HPG posts, GP hospitals and units, GP beds, access to diagnostic facilities.

5.5 Medico-political functions

The LMC is an independent self-financing body with statutory functions (as distinct from a state funded statutory body). Its independent status allows it to exercise medico-political functions in addition to statutory functions. This duality of function is unique and contributes to the power of the LMC. The statutory functions are concerned mostly with the interests of the individual general practitioner in relation to his contract with the HA and the continuing dialogue between the LMC and HA. On the other hand, the medico-political functions are primarily concerned with the collective interests of general practitioners as a group, and these operate through a quite separate channel consisting of LMC/conference of LMCs/GPC/NHSE. If this channel of communication is to be effective, the flow of information must work in both directions; from the LMC to the GPC and vice versa.

In some areas, regional committees of LMCs have existed for some time, as a forum for discussing supra-district problems and exchanging ideas and, it makes sense for LMCs to seek to act collectively via a regional committee in formulating policy on a regional basis. A regional committee of LMCs could increasingly become the focal point of consultation with and representations to HAs. The future for regional committees of LMCs is, therefore, very important for NHS general practice.

5.6 General Practitioners Committee

The GPC is the standing committee of the BMA with full authority to deal with all matters affecting NHS general practitioners. It is the only body which represents all general practitioners (whether or not they are BMA members) and is recognised by the Department of Health as NHS GPs' sole negotiating body. The GPC is responsible for determining what advice should be given, and what representations should be made, to the secretary of state and DoH officials. Although the GPC is responsible ultimately for policy, it cannot, and would not, formulate its policies in a vacuum. It therefore convenes annually (and on other special occasions) a conference of representatives of LMCs. For each conference the GPC prepares a report, a copy of which is sent to every general practitioner, who then has the opportunity of expressing a view through his elected representative on the LMC, or at a meeting of all general practitioners held in the LMC's area.

Whatever procedure is adopted, it is for the LMC to submit motions for inclusion on the agenda of the conference. Such motions, if carried, are referred to the GPC and provide a firm basis for formulating policy. It is this democratic process which gives meaning and strength to the GPC in its day-to-day representation of the interests of family doctors in the NHS.

This outline of the LMC conference/GPC structure shows how general practitioners have chosen to exercise 'self-government' through their elected LMCs. Every part of the United Kingdom has at least one spokesman on the GPC, a doctor in active practice, to present its views and problems, as they affect negotiations for general practitioners as a whole, or, on occasion, individual practitioners.

5.7 **General Medical Services Defence Fund**

The profession has chosen this representative system and it involves considerable expenditure of time and money. The defence fund, which was first established in 1913, is the main source of finance for running this democratic process. The term 'defence' may appear to be a misnomer if you take a narrow definition which merely applies to some form of direct action against government, e.g. the collection of undated resignations from the NHS. However, the work of the GPC, and its various subcommittees, and working parties, is for the purpose of defending the interests of general practitioners in relation to their terms and conditions of service, even though the profession may not be involved in a confrontation with government on some specific issue. All this activity costs money (members of the GPC are reimbursed their expenses) and the NHS benefits directly. It could be said this is the necessary price the profession has to pay for 'self-government'.

5.8 **Statutory levy**

The statutory levy which can now cover both GMS deputies and pilot scheme providers and performers is quite distinct from the voluntary levies which GPs are asked to pay as a contribution to the 'defence fund' and to defray LMCs' exceptional costs. The statutory levy may be used only for defraying the committees administrative expenses; defined to include travelling and subsistence allowances payable to members of the Committee but not insofar as they relate to administrative expenses arising from deputy or PMS practitioners. The legislation enables an LMC to make a compulsory statutory levy on every general practitioner who satisfies the conditions of section 44 of the 1977 Act to meet these specified expenses (but no more) and these are open to external scrutiny. The administrative expenses of an LMC are the only expenses that may be collected by statutory levy and they are deducted by the HA from doctors' NHS remuneration and paid over to the LMC.

5.9 **Voluntary levy**

LMCs additionally raise a voluntary levy which provides for contributions to the "defence fund" and to defray LMC costs which cannot be covered by the statutory levy.

F. Conclusion

6. This summary of the work of the LMC does not claim to be comprehensive as the work is complex and covers so many areas. It is recognised that the roles and functions of the LMC are rapidly changing to promote the development of general practice in a period of financial stringency and organisational change.