# *Good Doctors, Safer Patients*: a chance to move on

Sir Liam Donaldson's report, *Good Doctors, Safer Patients*, was published on 14 July 2006 and makes 44 recommendations (Department of Health, 2006a). The government is consulting on the report (and on a parallel report on the regulation of other health-care professionals) (Department of Health, 2006b). The statement from the General Medical Council (GMC) marking the publication of the report underlined that the starting point for the GMC in developing its response to the report is its statutory purpose – to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine (www.gmc-uk.org). The GMC expressed support for some of the proposals, said that others would need careful consideration, but warned that the proposals in relation to medical education, which would take away from the GMC's responsibility for undergraduate medical education, would not be in patients' best interests.

This article focuses on those proposals in particular, but also explains why this now provides a real opportunity to embed a framework of independent medical regulation which puts patients first, fosters doctors' professionalism and enjoys widespread confidence and support.

## Proposals for medical education

The report's medical education proposals have found little support even from those who otherwise claim fully to support the overall package (Irvine, 2006). However, much of the debate so far has been superficial and has focused on transient issues including around the Postgraduate Medical Education and Training Board's (PMETB)'s current capacity, track-record and accountability, which, given that the PMETB is a new organization, is unfair. Debates about these largely second order questions miss the real issue at stake, which is about which model will be best for patients.

*Good Doctors, Safer Patients* points out that responsibility for medical education is, at present, somewhat fragmented. Fragmentation of regulatory responsibilities more widely is unhelpful and likely to be confusing for patients. Sir Liam is also surely right to say that 'it is not good for public confidence in medical regulation to see the main regulatory body so often mired in controversy' (Department of Health, 2006a). This controversy is not good for doctors either.

## Risk of fragmentation

Despite its good intentions, the report's recommendations would not resolve these problems; far from achieving coordination and coherence they would scatter responsibility for regulation in different directions, with PMETB, the medical Royal Colleges and the GMC all involved, but with no one ultimately responsible. The effect would be to fragment accountability for the fitness for purpose of the medical register to the point that it will virtually disappear.

A doctor's entry on the register, instead of being a mark of quality underpinned by clear, transparent standards which the profession, the public, health-care organizations and the medical schools and Royal Colleges jointly own and feel confident in, will become a mere directory of names, divorced from the functions which should underpin it and give it meaning. The GMC cannot be held accountable for the fitness for purpose of the register if it cannot control entry to it.

As a matter of principle, it would not be acceptable if the body which was the custodian of standards of good practice were controlled by the Department of Health which, through the NHS, is the near monopoly provider or commissioner of care. Regulation which is not independent is simply not worth having. In the debate so far, it is disappointing that this point has not been heard with greater clarity.

## Moving forward

So is there a solution which would lead to greater integration of regulatory functions and yet, retaining the strengths of independent regulation, would enable medicine to move on from the battles which have dogged medical regulation for many years?

The author believes that there is. So far as education itself is concerned, the GMC should now be given the opportunity to build upon its existing responsibility for the coordination of all stages of medical education retaining the essential links to its other regulatory functions.

This aim could be delivered in a number of ways. For example, the education committee of the GMC could oversee three boards which reported in to it, one for undergraduate education, one for postgraduate education and one for continuing professional development and post-Certificate of Completion of Training education and training. But there are other options. It would be sensible to explore how this improved coordination could be achieved with the minimum of disruption to existing structures. Considerable progress could be made through partnership working and close collaboration.

## Further reform of the GMC

The GMC, across all its functions, has made huge progress in engaging with patients, the public, employers of doctors, and the medical schools and Royal Colleges in determining and embedding the qualities now expected of doctors. Despite this, there has continued to be considerable criticism of the GMC, although most vocally from those who are out of touch with what the reformed GMC and its committees – including the education committee – have, since 2003, been doing and delivering. But the GMC has to accept that even with greater transparency, wider engagement and an increase in lay membership of the council to 40% since 2003, neither government or parliament have felt able to express unqualified confidence in the ability of the GMC to deliver its purpose without fear or favour. In the author's view, a major stumbling block is the negative perception of the professional majority on the council. The perception is unfair, but it still undermines confidence in the

GMC's independence and impacts adversely on their ability to regulate effectively.

If medical regulation is to move forward with confidence, the GMC needs to go beyond engagement with its constituencies and actually give them a voice on its council. A balanced composition is needed, made up from:

1. Patients and the public
2. Doctors
3. The NHS and other health-care providers
4. The medical schools and Royal Colleges.

Council members would each bring their own experience, competencies and perspective to bear, but their over-riding loyalty must be to the public interest and the protection of patients. They must operate (as the GMC increasingly has done) as a coherent, corporate whole, not as a collection of factions. The routes by which members come onto the GMC must enhance confidence in the GMC as an independent body separate from the government of the day.

The point of principle that must be held fast to is that the re-constituted GMC needs to command the confidence of each of its main constituencies – and of government and parliament. This can be done in a way which will continue to enable doctors to feel a sense of ownership of the principles and values of good practice. It is vital for patients that they do.

It is time for medical regulation finally to move on; the opportunity which *Good Doctors, Safer Patients* provides to do just that must not be wasted. **BJHM**

## KEY POINTS

- The General Medical Council (GMC)'s starting point in responding to *Good Doctors, Safer Patients* is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.
- The GMC welcomes some of Sir Liam's proposals but have serious concerns about removing the responsibility for undergraduate medical education from the regulator.
- The best model for patients in terms of medical education is to secure a coordinated approach for undergraduate, postgraduate and continuing education, with improved representation for patients and employers.
- If medical regulation is to move forward with confidence we need a GMC which has a balanced composition including patients and the public; doctors; the NHS and other health-care providers; the medical schools and Royal Colleges.

**Graeme Catto**
*President*
*General Medical Council*
*London NW1 3JN*

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