Medical regulation: promoting excellence and safety

The report *Good Doctors, Safer Patients* (Department of Health, 2006), recently published by Sir Liam Donaldson, Chief Medical Officer of England, has generated a great deal of interest and debate in the General Medical Council (GMC) and the medical profession at large. Sir Liam has made 44 recommendations and consults on key changes in medical education and regulation. This editorial reflects on some of these recommendations regarding medical education and regulation in order to take it forward to produce excellent doctors working in an environment where patients are assured of safe and quality health care.

Medical education and training

Medical education and training should provide the knowledge, skills and attitudes deemed essential for competent doctors. The training should be fit for purpose and not only should it provide technical competencies but also the professional skills necessary to deliver care to patients. However, it is necessary to understand that learning is a lifelong process and that with the time constraints of medical training it is hardly possible to master all the professional skills. Doctors, as part of their continuous professional development, should be encouraged to learn additional skills, including 'soft' skills, while keeping up with the acquired ones.

Over the years the NHS has attracted doctors from abroad because UK has been regarded as being a leader in medical training. To ensure good quality care to our patients and to provide the safety and protection they deserve, it is necessary for these doctors to be as competent as UK graduates.

Effective communication skills are essential for doctors to carry out professional roles and develop successful relationships with patients and team building with colleagues. Time and again concerns have been raised regarding their communication skills. The NHS needs a system to standardize the assessment of doctors' skills and knowledge that is non-discriminatory, fair and transparent. In USA, all doctors irrespective of their country of graduation are required to pass an examination (USMLE 3) before commencing clinical training. Such an examination for all medical graduates including those from the UK would be useful to build public trust and confidence in the medical profession and to dispel perceived discrimination against overseas doctors.

Quality of medical practice

The medical profession has embraced annual appraisal as part of their terms and conditions of employment and has found this culture change useful for their professional development. The appraisal process also needs to be standardized, regularly audited, monitored and improved. This cannot be achieved without the provision of adequate time and resources. The present appraisal system requires practitioners to demonstrate competence in all the components of *Good Medical Practice* as laid down by the GMC (2006). The Clinical Negligence Scheme for Trusts accepts appraisal as part of its risk assessment and patient safety. Sir Liam states:

> **'appraisal is a positive developmental process which helps the individual practitioners to ensure that their contribution is a high quality one. Appraisal – and through it the link to revalidation – will also give patients confidence that the doctor who is caring for them is up to date, reflective in their practice and keen to find new ways of improving their service'. (Donaldson, 2006)**

The appraisal process should be strengthened and form the foundation for periodical revalidation. It, of course, should be supported by provision of suitable training to help bridge the gaps identified. Involvement of lay people in this process will improve public confidence and bring transparency and credibility.

Professional regulation

The GMC's efforts towards reforming itself need to be recognized and appreciated. It has worked towards implementing changes necessary to ensure that doctors continue to provide high quality care to their patients. In doing so, the interests of public are protected and the standing of the profession is maintained.

Most of the investigation and adjudication is carried out by trained medical and lay people appointed as GMC associates. There is clear distinction between the investigation and the adjudication phase when concerns regarding medical practitioners' performance, health or conduct are scrutinized. The present GMC is far from the one once perceived as being prosecutor, judge and jury. However, it also continues to attract wide criticism, especially in terms of achieving equality and diversity. The authors are convinced that regulation should result in swift, fair and timely decision-making underpinning the values and principles of equality and diversity. It is also an essential prerequisite that the regulation is and is perceived to be fully independent, aiming to decrease the burden of regulation.

The current pool of highly skilled and trained case investigators, performance assessors and adjudication panel members of various regulatory bodies, such as the GMC, General Dental Council and the Law Society, could be made available to NHS trusts and strategic health authorities to investigate concerns raised against health professionals locally. The regulatory body should be a more public friendly organization and engage itself in regular dialogues and road shows. The authors strongly feel that it can only be for the good of doctors if patients have confidence in their regulation that is open and transparent.

Society rightly expects highest standards from doctors. However, post-Shipman there is a growing perception that a minimal fall in standards by doctors may lead to severe consequences. Doctors have expressed anxiety that the lowering of the burden of proof from a criminal to a civil standard during adjudication could, unfairly, lead to too many doctors having restricted registration or even erasure of their names from the medical register. If this occurred, it could have a disastrous effect on the doctors' employment and compromise patient care as it may exacerbate the problem of recruitment and retention of doctors.

Conclusions

There is a threat to medical professionalism. A petition to that effect signed by doctors and patients was recently published in *The Times* (Querci della Rovere et al, 2006). In recent years the profession has been invaded by a never-ending series of changes and increased bureaucratic interference. This has resulted in low morale among medical practitioners, which cannot be good for patients. It is only right that doctors maintain high professionalism by strengthening the patient–doctor relationship. It is time that doctors are supported in their endeavour to serve patients to their best ability and enjoy public confidence. BJHM

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Department of Health (2006) *Good Doctors, Safer Patients.* DH, London
Donaldson L (2002) Foreword. In: Lingam S, Gupta R, Gormley B, eds. *Appraisal in Medicine.* Blackwell Science, Oxford: vi
General Medical Council (2006) *Good Medical Practice.* GMC, London
Querci della Rovere G, McCartney M, Thornton H et al (2006) New check-ups for doctors. *The Times* **October 17:** 18

KEY POINTS

- Medical regulation needs to move forward towards creating excellent doctors delivering safe health care.
- Principles of lifelong learning and continuing professional development are an integral part of medical education.
- The adjudication function needs to be truly independent, delivering swift timely decisions underpinning values of equality and human rights.
- A doctor–patient relationship based on openness, trust and good communication will enhance the quality and safety of health care.