

Self-regulation: what is the future?

These last few months have been an extraordinary time for the medical profession. No-one can be unaware of the media interest in doctors, and their clinical performance (much coverage being highly critical), and also of the government's statements concerning the regulation of the profession. As the *British Medical Journal* leader put it, after the verdicts of the General Medical Council (GMC) on the Bristol heart surgeons were announced, 'All changed, changed utterly' (Smith, 1998a).

In the consultation document on quality in the new modern dependable NHS, *A First Class Service*, the government committed itself to a modernized professional self-regulation, to deliver higher quality standards. However, following the scandals of Bristol and the case of the Kent gynaecologist struck off the medical register after a series of patients' complaints of poor operating skills, there is strong public criticism. Voices are being raised mainly from outside the profession, but also within it, questioning if self-regulation has a future. Can doctors be trusted to monitor their own performance? Do doctors just try to protect themselves from patients rather than protecting patients from poorly performing doctors?

NATURE OF SELF-REGULATION

The nature of self-regulation for doctors working in the NHS is already changing. Health Minister, Alan Milburn, has spelt out extra powers for the proposed Commission for Health Improvement (CHI). In addition to cycles of visits to hospitals and primary care every 3–4 years, with monitoring of individual doctors audit results, CHI has been given

power to issue immediate 'public interest reports'. If a unit has problems with standards of clinical services (based on data about the performance of individual doctors) that are so serious that patients are placed at risk, CHI will issue a report naming individual doctors which will then be published.

If doctors and managers do not acknowledge the seriousness of problems within their own units, CHI can recommend to the Secretary of State that he/she send in new teams of experienced doctors, nurses and managers, to take over the running of 'failing' services. The details of the implementation of these proposals have not yet been discussed, but the intention is clear — more close monitoring of doctors who work in the NHS, by a body which will undoubtedly have a large lay representation.

LEGISLATION

The government has also taken more powers to itself to amend legislation governing professional regulatory bodies, including the GMC. Although the stated intention was to make tidying up legislation easier, to streamline procedures in the regulating bodies when parliamentary time is at a premium, the timing of such changes, in the current political climate, is interesting. The government has strengthened its ability to respond to public outrage if it can quickly change legislation covering the GMC (Smith, 1998b).

So where is the profession now? It has to make a positive response to public concern, and to show it can make self-regulation work.

STANDARDS FOR DOCTORS

The GMC sets positive standards for individual doctors, and in *Good Medical Practice* (GMC, 1998) it is

made clear that all doctors have a duty to keep up-to-date, to participate in audit, to work within the limits of their own professional competence and also to protect patients if they feel that they themselves or a colleague is harming patients because of problems with health, conduct or performance. The latter duty is now much more emphasized and demands a change in culture in the profession, whereby poor performance is confronted, not covered up.

Professional self-regulation has to be made to work locally — in individual units, in individual hospitals and in individual clinical teams (Irvine, 1997a,b). Robust systems of clinical audit, both local and national (supported by the necessary information technology), have to be in place and a culture of openness has to be present.

Ongoing continuing professional development for all doctors will need to be implemented — not just the sterile 'getting the points' for continuing medical education but individualized lifelong learning. This means constantly keeping up-to-date and striving to implement best practice, alongside a reflection on current practice. Senior medical staff have never been given the support of appraisal and feedback — this will need to be developed. A positive learning process from patients' complaints can also help to improve practice, and risk management can point to areas for improvement.

SELF-REGULATION AND CLINICAL GOVERNANCE

All the above will form part of clinical governance, the systems to be implemented in the NHS for continuing quality improvement (Scally and Donaldson, 1998). National service

frameworks next year in services for coronary artery disease and mental health and reported clinical indicators will also review local practice.

Robust local systems are needed to deal with dysfunctional doctors — to recognize problems early and to put in corrective action when appropriate. The emphasis should be on practical help and support so that doctors who get into difficulties can be restored to practice if this is possible, without putting patients at risk. If situations cannot be handled locally, then individual doctors can be referred to the GMC, and dealt with under the new performance procedures (where a pattern of performance can be

assessed), the health procedures or conduct procedures.

The public also want to be assured that doctors are currently competent — mandatory revalidation has many lay supporters and is currently being debated in the profession. A positive response would signal the profession's intention to really tackle the issues of poor performance and continuing improvement for all doctors (Horton, 1998).

This is a daunting agenda — the profession is feeling battered by poor publicity, increasing clinical demands, initiatives to cut waiting lists, rising medical emergencies etc, and may very well respond by a

defensive attitude that 'it can't be done' and feel the demands being made are unreasonable.

However, a failure to act constructively and to run with the new agenda, seeking out opportunities to practise better medicine in a culture of openness will result in a further loss of confidence in us by the public. Regulation will then assuredly be imposed from outside the profession. That is the challenge facing us. **HM**

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KEY POINTS

- There is a loss of confidence in the profession by the public.
- Professional self-regulation is under threat.
- All doctors have a duty to maintain good practice.
- Patients must be protected from poor practice.
- Robust local self-regulation is essential.
- Clinical governance must be made to work.

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Smith R (1998b) Repositioning self-regulation. *Br Med J* **317**: 764