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Editorial

Good doctors, safer patients: opportunity knocks

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On 14 July 2006 the Chief Medical Officer (CMO) for England, Professor Sir Liam Donaldson, published his long-awaited review into the quality assurance and safety of doctors' practice in the UK, including the system for medical regulation. The Royal College of General Practitioners (RCGP) has published a concise summary of the report.[1] *Good Doctors, Safer Patients* responds primarily to the recommendations of the Fifth Report of the Shipman Inquiry,[2] which examined the role of the General Medical Council (GMC) and the broader arrangements for medical regulation. In her 2004 report, Chair of the Shipman Inquiry, Dame Janet Smith, had concluded that NHS procedures for detecting and dealing with poor clinical performance were inadequate, allowing problems with a doctor's performance to extend over many years without definitive action being taken. The absence of rules on information sharing between professional, educational and regulatory bodies and NHS employers meant that concerns about a doctor were seldom collated at an early enough stage. This was coupled with a culture that lacked true patient-centredness, so that the interests of patients were often subordinated to other considerations. Dame Janet was also critical of the GMC, concluding that its culture, membership, methods of working and governance structures were too likely to support the interests of doctors rather than protect patients. The Shipman Inquiry and others' criticism of the proposed approach to revalidation of all doctors' fitness to practise is also central to the review.

Over ten chapters and 44 recommendations, *Good Doctors, Safer Patients* proposes how the assessment of doctors, complaint systems, the identification and sharing of information on poor medical performance, care delivery and the role of the GMC could be made more effective and robust.[2] Central to such recommendations is the concept that medical regulation should *not* be limited to the identification of poor practice but is a partnership of doctors, patients and regulators working towards the general enhancement of quality in healthcare. Integral to these arrangements should be a universally agreed definition of a 'good doctor', operationalised into an easily assessed set of standards and systematically linked to local processes for assuring and improving care quality and patient safety. This should be facilitated by the devolution of regulation towards the regulated unit (local workplace) and away from central, statutory or governmental regulators. The report also makes a commitment to a comeback for clinical audit – this I am sure will be celebrated by readers of *Quality in Primary Care.*

Good Doctors, Safer Patients is the first substantive review of regulation for over 30 years and aims to bring 'clarity and coherence across professional regulation and to agree where the proper responsibilities should lie between practitioners, employers, professional regulators and systems regulators'.[2] The report found that:

> the structural response to the governance agenda has not been fully matched by a behavioural and cultural shift in local approaches to the issues of safety and quality.

And it goes on to say 'there is also a marked variation in adherence to best practice standards in different parts of the country and in different clinical services'. Medical regulation has long been a source of controversy, and in a devastating critique of it, the CMO characterises this as a 'culture of inaction'.

The RCGP has confirmed its support for the principles outlined in the report of:

- the better alignment of professional regulation with NHS systems
- simplifying and making better regulatory processes
- ensuring public involvement, accountability and transparency.[3]

With qualifications in a number of areas, the RCGP believes that the report, if properly implemented and supported, will be an important opportunity to improve the quality and safety of patient care, particularly the proposal for the twin track revalidation process of relicensure and recertification, and also the recommendation that each medical Royal College

should set the standards for specialist medical practice. The RCGP has stated that it rules out the use of routine, mandatory high-stakes formal examination as a way of revalidating doctors.

Clearly, in a report of this magnitude on a complex topic there are bound to be controversial recommendations. Some recommendations, particularly those around revalidation, have received broad support but others, such as transferring the undergraduate education function of the GMC to the Postgraduate Medical Education and Training Board (PMETB) have been opposed outright. Although there is general acceptance that unification of the education standard-setting function in undergraduate, foundation and postgraduate medical education is desirable, there are concerns expressed about which organisation, the PMETB or the GMC, should oversee this. The report signals that the PMETB should assume the unified function, but there exist significant concerns about this and there is a counter-proposal from the GMC. Clearly these and other issues need further discussion.

There has also been concern from the profession about the proposal to change the burden of proof to a civil standard; however, the regulator, the GMC, has already in effect conceded the issue by putting forward the use of a 'sliding scale' principle. The GMC has also put forward proposals for changing itself, including calling for a balanced composition of its council. There is also considerable debate and concern about GMC affiliates. The arguments centre on whether a single individual can deliver this role and how it is consistent with the medical director role. A number of different models have been put forward including one from the RCGP, e.g. the idea of panels consisting of doctors and lay assessors. There is, however, general agreement that there should be a strengthening of the relationship between the professional regulator and the NHS at local level, and it is absolutely essential that we achieve this. Those who argue that a trust employed medical director can fulfil the GMC role as well need to address the obvious issue of conflict of interest and the fact that the medical director role is neither well developed and recognised, particularly in primary care, nor is it consistently effective.

What, therefore, are the important issues and how can we retain the focus on the 'big picture'? The report has been launched for consultation, and as I write this, we await with a great sense of anticipation, the government's response. What will the government's response be? Will it be big change or small change? Will it be radical or will it be 'tinkering at the edges'? One thing is for sure: there has been no shortage of analysis. It is knowing what to do next that is important.

My first comment is that action must be taken to move the situation forward. It is now nearly 10 years since the GMC first put forward its ideas for revalidation. There has been broad acceptance in the medical profession for the need for revalidation, but disagreement over the purpose and methodology means that the system has not yet been implemented. This is at a time when authoritative polls conducted by MORI, as reported in *Good Doctors, Safer Patients*, show that the public 'believes systems are already in place to ensure that any doctor they might consult is up to date and competent in their field'. It goes on to say that 'the public and the medical profession wish for such an assessment to take place regularly (certainly every few years). Such systems are not in place'.[2]

We have not yet therefore reached a situation where a patient seeing a doctor in the UK can be confident that the doctor has been verified as being 'above the line' to fit to practise. That is the place we want to be in. So let us affirm this commitment: revalidation is necessary and important, and should be implemented as soon as is practicable. The twin track revalidation model (relicensing and recertification) has logic to it. It links the NHS clinical governance process, which will deliver relicensing with Royal Colleges' professional curricula and competences which will deliver recertification.

I have previously written about the fragmentation of the quality system in our health system – with a multitude of standard setters, poor exchange of information and an NHS complaints system that needs to become more responsive.[4] I also wrote that clarity is needed on the different quality and safety processes and to define the inter-relationships, e.g. the links between Royal Colleges and regulatory systems. I expressed a wish that what should emerge from reviews is an overarching vision of an integrated, comprehensive and patient-centred system for quality and safety of healthcare in the NHS. Donaldson offers a framework and a way forward.

Looked at in the 'big picture', it is my view that the Donaldson report represents an opportunity to put in place a sound and necessary system of regulation that is supportive of patients and also doctors. I write as someone who has been involved in clinical governance in primary care organisations, including as a general practitioner (GP) appraiser and a practice visitor. From this and involvement at a national level in regulation and quality, I am convinced that change is needed. If the principles and key proposals are 'watered down', then this will be regarded as expediency, exactly the charge levelled at the GMC by Dame Janet Smith in the Shipman Inquiries. Obviously we hope that as a result of the constructive suggestions made in the consultation, some of the recommendations will be refined and improved – but there is no 'plan B'.

Patients expect the health community to move this issue forward. Will the health community rise to the challenge? The stakes are high. There is an obligation

on all of us to rise to the challenge so that we have the best possible system to assure the quality and safety of healthcare in the UK. The time has come to move from discussion to delivery.

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