

## Commentary (Series editor: David Taylor)

# Professionally led regulation in medicine

The power of any profession to regulate itself is a privilege given by the state through parliament and not a right.<sup>1</sup> If society loses its confidence in the ability of the profession to exercise that right responsibly the possibility of alternative methods of regulation naturally arises. Recent high profile cases of serious professional misconduct or seriously deficient performance by doctors in the UK in recent months have dented that confidence somewhat, and sensationalised reporting in the media has done nothing to help the situation.<sup>2</sup> It is encouraging, however, that in a recent public opinion poll conducted by MORI on behalf of the BMA, 87% of those polled said they would generally trust doctors to tell the truth. Only 7% of members of the public responding were dissatisfied with the way doctors do their jobs.<sup>3</sup>

A number of advantages accrue from a regulatory system that is controlled by the medical profession. Most people are reassured to know that doctors not only have contractual obligations to any employer but also professional obligations to live up to the standards of conduct, performance, and behaviour set by their peers, as these are invariably more demanding than any contractual ones. For self employed doctors, professional accountability is perhaps even more important. Doctors are also likely to have more confidence in a regulatory body for which they feel a degree of ownership than in external regulation; the teaching profession provides an example of the effect of externally imposed regulation on morale. Doctors are in a good position to define the standards that they expect of themselves and their colleagues, and these standards have been clearly expressed by the General Medical Council (GMC) in its document *Good Medical Practice*.<sup>4</sup> There is, however, widespread recognition by the profession that strong non-medical input is essential, both in the setting and ownership of standards and in applying them; this reflects a growing, if belated, awareness of consumer rights. This recognition has led to the increasing use of the term “professionally led regulation,” rather than “professional self regulation.” In 1996 the lay membership of the GMC was increased from 10% to 25%, and a further increase is likely to be recommended.

Professional regulation is a dynamic process, flowing from the responsibilities of individuals, through those of clinical teams and local groups to the national regulatory body. *Good Medical Practice* makes it clear that individual doctors have responsibility for recognising and working within the limits of their professional competence in providing care. They must keep their knowledge and skills up to date throughout their working life, taking part in regular audit and responding constructively to assessments and appraisals of their professional competence and performance. In order to do this they need to reflect on the adequacy of their training in relation to current expectations of them, the adequacy of their continuing experience, and the continuing professional development of their knowledge and skills. Doctors are busy people and finding time to stand back and reflect on these matters is not easy to achieve. Their contracts should recognise the fact that continuous professional development is as important as teaching and administration.

Local clinical teams have responsibility for setting and maintaining collective standards. They must take collective responsibility for the clinical service they provide, recognise the limits of the environment in which they work, and ensure that these limits are not exceeded. They must also work with colleagues in ways that best serve patients' interests. Dysfunctional relationships unfortunately occur within departments of ophthalmology as in all other hospital departments. The culture in which doctors work has not, in the past, been conducive to good teamwork and, in many instances, this has been a weak link in the chain of professional regulation. There has sometimes been a reluctance to take appropriate action when faced with evidence of unacceptable practice, and the fear of litigation has discouraged some from admitting their own mistakes. Effective local procedures within trusts and departments may be able to identify problems and enable appropriate action to be taken at an early stage, avoiding the need for referral to the GMC.

Clinical governance initiatives are designed to improve and audit local quality assurance systems, but a fundamental change to a blame-free culture is required. The fact that outcomes are known to be good following cataract surgery, for example, must not be used to accuse a surgeon of poor performance when the inevitable poor result occurs. Even the best doctors have their failures and may make mistakes from time to time—a fact that has not always been widely understood. On the other hand, in a subject like ophthalmology where success rates are generally high it may be difficult for individuals to accept the need for improvement when it arises. The announcement by the chief medical officer that, in future, all doctors working within the National Health Service must be subject to annual appraisal may provide a framework within which doctors can help each other reflect on their professional development in a formative, non-threatening way. Doctors who have been subject to regular appraisal during training will find it particularly easy to recognise the advantages of such a system. These include the opportunity to identify particular training needs, such as the learning of new skills in the light of rapidly changing clinical practice, and to obtain help in achieving any desired career development plans. Members of the public are frequently surprised that a system of appraisal is not currently in place for senior medical staff. It is to be hoped that in England the government's proposed performance assessment and support services will provide impartial support to the employer in an environment supportive to doctors whose performance is in doubt.<sup>5</sup>

The UK doctors' regulatory body, the GMC, was established under the Medical Act of 1858 and for many years its disciplinary activities dealt solely with “infamous behaviour,” now known as “serious professional misconduct.” Doctors accused of such misconduct were, and still are, subject to a quasijudicial procedure, in which specific allegations are currently prosecuted against the burden of proof required by the criminal courts—“beyond reasonable doubt.” The standard of proof is currently under review for all healthcare regulatory bodies. Since the law requires these specific allegations to be identified before

the hearing, issues of professional competence or behaviour that may become evident during the hearing but are not related to the allegations cannot be dealt with, even though they may pose a risk to public safety. There is no opportunity for remedial training for doctors under the “conduct” procedures, which in the worst cases may lead to erasure from the medical register.

In 1980 the GMC introduced its health procedures, dealing with doctors whose professional performance may be affected by illness. These procedures are conducted on an inquisitorial, rather than adversarial basis and although patient safety remains paramount, every attempt is made to treat and rehabilitate the sick doctor. In 1997, the performance procedures were established, designed to assess not only what doctors are capable of doing (competence) but also whether they fulfil their potential in everyday practice (performance). The aim is to protect patients from those doctors who, while not guilty of misconduct or affected by illness, have nevertheless repeatedly and persistently demonstrated unacceptable levels of performance.<sup>6</sup> However, as with the health procedures, every attempt is made to identify remedial areas of deficiency and to encourage retraining and rehabilitation of the doctor.

The establishment of the performance procedures has for the first time introduced a national standard for the identification of seriously deficient performance across all medical disciplines in the UK, applicable to doctors at any stage of their career. Doctors whose performance is allegedly seriously deficient may be invited to undertake an assessment carried out by two medical assessors from the same specialty as the doctor and one non-medical assessor. All assessors are appointed and trained by the GMC and the assessment process has been developed and validated over a number of years with expert advice from around the world. Although much of the assessment is generic, specialty specific aspects have been developed for all branches of medicine. In preparation for the assessment doctors complete a comprehensive portfolio in which they describe their job plan, document their continuing medical educational (CME) achievements, and attempt a self assessment of their performance. The actual assessment is in two parts. Phase 1, carried out at the doctor's place of work and lasting for at least 2 days, is tailored to the doctor's area of practice. It comprises a structured review of record keeping, a case based interview, interviews with a wide range of third parties, observation of actual practice where appropriate, and an evaluation of any environmental factors that may affect the doctor's performance. If the evidence at the end of phase 1 suggests serious deficiencies of knowledge or skills (including communication skills), a phase 2 off-site test of these aspects of competence is carried out. While every attempt is made to encourage the doctor to undertake this assessment on a voluntary basis, the GMC has the power to require an assessment to be carried out. Similarly, though it is hoped that doctors will accept any recommendations and undertake any retraining required, the Committee on Professional Performance has the power to restrict or suspend them from medical practice if necessary for the protection of patient safety. The Federation of Medical Licensing Authorities of Canada has developed similar methods, though the second stage assessment of competence has only been developed for family practice and not for other specialties. The GMC is therefore at the forefront of the development of methods of assessing the performance of allegedly deficient doctors.<sup>7</sup>

It has become clear in recent years that the GMC's current fitness to practice procedures, relying as they do on

#### Self regulation and ophthalmologists

- Continuing medical education and professional development will be essential for all ophthalmologists.
- Consultant ophthalmologists will have to define their areas of expertise and ensure that their practice is confined to those areas unless they undergo meaningful further training.
- Continuing audit and regular appraisals will be mandatory.
- Ophthalmologists are expected to work as members of a team and not in isolation.
- Revalidation of medical registration is likely to be started soon.
- All doctors must take appropriate local action if they believe that the performance of a colleague might endanger patients. Early local identification of problems and appropriate action may prevent the need for referral to the GMC.
- A blame-free atmosphere within the profession of openness about unexpected outcomes, professional misjudgments, and errors is important to improve safety systems. Reporting of even minor incidents, if acted on, will improve those systems.
- Self regulation has to be a partnership between the profession and employers.

the reporting of alleged deficiencies to the GMC by individuals or groups, does not give the public and parliament the assurances they require with regard to regulation of the profession. It has therefore been agreed that, in future, all doctors will be required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field. Revalidation of medical registration is primarily a means of performance enhancement that will require evidence of a rolling programme of appropriate continual professional development, regular appraisal, and satisfactory performance in all the main areas of good medical practice. The evidence provided by each doctor will be assessed every 5 years by two doctors and a non-medical assessor appointed and trained by the GMC. The few whose registration is not revalidated may be required to undertake the GMC's performance assessment described above. Again the GMC is stressing the importance of assessing actual performance day to day in the workplace. Other licensing authorities, notably those in Canada and Australia, are also incorporating more performance based criteria into their recertification processes. Most countries, however, rely on either voluntary CME programmes or recertification by examination and accumulation of CME credits, neither of which has been shown to correlate well with actual clinical performance.

To be successful, the GMC's proactive performance based revalidation process must be simple, and must work in collaboration with managerially led initiatives, particularly appraisal, and the other fundamental aspects of clinical governance. If these work properly there should be no surprises for the individual doctor at the time of the revalidation decision. Self regulation starts at a personal level, includes regulation within teams, and must fit closely with hospitals' own managerial systems. Some of the recent criticisms of the profession and its regulators have reflected failures in the NHS complaints system and weaknesses in local management that the Commission for Health Improvement must address. The chief medical officer is on record as saying “We are not playing one club golf.” It is essential that the two main clubs in the bag, professionally

led regulation and clinical governance, allow the course to be completed uneventfully with successful negotiation of any hazards encountered on the way.

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