Donaldson states that there is no universally agreed definition of a good doctor and that there needs to be. But evidence is abundant that the public want doctors who are technically competent; give them the best possible clinical outcome; are as safe as possible; are kind, courteous, and respectful; and involve them in decisions about their care. All of these basic elements matter—they are not optional.^{6,7} In fact, they are all there, and more, in *Good Medical Practice* and the derivative versions developed by the royal colleges. It is getting all doctors to sign up that is the problem. As the report says, the way forward lies in making both generic and specialty standards capable of being fully operationalised. That means criteria, thresholds, and sources of evidence for assessment.

In making what is a huge cultural transition, much will depend on medical leaders who have the courage and determination to take the agenda forward and who will not sacrifice the best interests of patients or the longer term interests of their profession on the altar of short term political expediency. Leadership has to come from the GMC, the royal colleges and specialist societies, and the medical schools—standards are their business. But it would be great if the BMA would join in too.

Benefits of change

The new professionalism offers advantages for doctors as individuals and as a profession. For individual doctors it offers the confidence that flows from knowing and being able to show others that they are on top of the job and so are regarded as absolutely reliable and trustworthy. Doctors who are self confident and self aware are more able to take control of their professional lives—to feel that they are not being driven by the system, as so many do today. Self confidence, self respect, and self control beget high morale.

The profession will gain from being seen to be firmly patient oriented and being able to show that its house is in good order. The result could be a measure of public trust and respect of which the collective profession today can only dream. This would be an immense strength for the profession and a civic force for good in a country where there is so much cynicism and mistrust about standards in public life. It would be particularly important as a counterweight in an NHS increasingly dominated by a target driven culture of managerialism that does not always seem to have the quality of patients' experience of health care foremost in mind.

The combined effect of Donaldson's measures could be quite profound. They should result in much stronger standards based, professional self regulation led by a revitalised GMC and the royal colleges. That would be reassuring to the public and patients, strengthen doctors' professionalism, and appeal to the huge majority of conscientious doctors who take pride in the standing of their profession. Tomorrow's doctors may well look back and wonder what all the fuss was about.

Competing interests: DI is a former president of the GMC.

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Independence is key to better regulation

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The chief medical officer's proposals represent an important shift away from the principles of professionally led regulation.¹ They dispense with elected medical representation on the General Medical Council, remove the medical majority, and transfer the GMC's adjudication function to an independent tribunal. The GMC now also espouses the concept of independent rather than professionally led regulation. Independence is fundamental to any profession. Neither the public nor practitioners are best served if medicine cannot marshal its own evidence and expertise against a near monopoly employer and the twists and turns of government policy.

Independence is not, however, a sufficient bulwark. The five principles of better regulation are accountability, consistency, proportionality, transparency, and targeting.² Donaldson proposes that the GMC be directly accountable to parliament, and that is welcome. The GMC must be accountable to patients, but it must also maintain a strong line of accountability to the profession that campaigned for it, submits to it, and funds it. If, as a society, we look to doctors to lead developments and innovation in clinical care for the benefit of patients, we must proceed with great caution

before embracing a set of measures that may seriously undermine doctors' sense of ownership of their profession. That sense of ownership is vital, not least to ensure that doctors feel confident to refer concerns about a colleague's fitness to practise for investigation.

Problems of local regulation

One of the recurring criticisms of our current system of regulation has been that minor problems that could and should have been dealt with earlier and locally are either ignored or referred inappropriately to the GMC. This adds to its workload, creates an unacceptable backlog of cases, and imposes a protracted period of stress and uncertainty on the doctor. Donaldson is proposing to tackle this issue—and to nip emerging performance problems in the bud—through a network of GMC affiliates. I believe this proposal to be unworkable in practice and objectionable in principle.

Donaldson argues that GMC affiliates will work alongside employers to provide a single line of sight on performance problems.¹ I do not find this plausible. Clinical governance is pre-eminently the responsibility of the employer or contracting body. We must not

create the risk that employers may shirk these important duties, leaving the task with GMC affiliates whose accounting lines are diffuse and unclear. The proposal meets neither the “better regulation” test of accountability, nor the requirement for transparency. We need to invest in and support the clinical governance role of health trusts. A regional profile for the GMC could add value here by encouraging dialogue and problem sharing within networks of medical directors and clinical governance leads.

Under the new proposal, when an investigation by the Healthcare Commission or the ombudsman uncovers evidence that casts doubt on a doctor's fitness to practise, public interest demands that the matter be investigated. However, neither of these organisations has the facilities or capacity to investigate and prepare a case against a doctor. The doctor must therefore be investigated by the GMC before referral to an adjudication panel.

Lively debate is ongoing over whether, once a doctor's case is before the GMC, the civil or the criminal standard of proof should be required. It seems unconscionable that a doctor be deprived of his or her right to practise and right to earn a living on the balance of probabilities. However, the regulators for teaching, social work, dentistry, and solicitors use the civil standard of proof. Legal commentators report that the civil standard is inherently a sliding scale, where the more serious the allegation, the more cogent the evidence required. We need to explore whether proportionality—the concept of a sliding scale—can be reconciled with the need for consistency and fairness for all parties.

Recertification

Central to Donaldson's proposals are recommendations for recertifying doctors' fitness to remain on the specialist or general practice register.¹ The proposal is for periodic assessment of competence led by the royal colleges. It is worth recalling that the purpose of revalidation is to protect patient safety and promote optimum care by ensuring that the doctor is performing appropriately. There is no point replicating the generic testing of knowledge required of medical students and doctors in training. Both general and consultant practice are highly specialised. The challenge for the colleges will be to devise and provide personalised, individual assessment of practice tailored to each doctor. They should genuinely improve outcomes for patients and meet the

tests of proportionality and targeting advocated by the Better Regulation Task Force.²

Proportionality and transparency demand that we build on existing mechanisms for assessing doctors' performance. I welcome Donaldson's emphasis on rehabilitation and remediation, but I think he is wrong to be dismissive of the existing appraisal system. What it lacks is the clinical authority and credibility that can only come by incorporating independent peer review into the process. I and many colleagues argued for this when appraisal was first mooted,³ but it was rejected on cost grounds. We could now strengthen trusts' competence in clinical governance and provide a meaningful check on doctors' practice by providing funding, not for GMC affiliates, but for independent peer review.

Control over education

Donaldson proposes that the GMC should lose responsibility for undergraduate medical education. The GMC's education committee has a statutory existence independent of the GMC, and I have high regard for its work. Rather than removing one of the fundamental building blocks of a profession—control of standards of entry—I think there is great merit in the GMC president's proposal to create a tripartite structure responsible to the education committee.⁴ This would consist of three boards covering undergraduate education, postgraduate education, and continuing professional development. A GMC continuing professional development board could provide independent oversight of the process of recertification offered by the royal colleges and employers.

The purpose of professional regulation is to serve the public interest, not to provide expensive and time consuming careers counselling for doctors. All Donaldson's proposals—whether for assessment, for 360° appraisal, for recording concerns at local level, or for changes to the structure and remit of the GMC—must produce tangible benefits for patients or must fall.

Competing interests: None declared.

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Many questions remain unanswered

Michael Buckley

Professor Liam Donaldson's report contains much that will be widely welcomed—it emphasises the need to safeguard and enhance patient safety.¹ But several of its recommendations raise questions of principle and others raise important questions of detail.

Shifting responsibilities

The way in which the General Medical Committee has discharged its responsibilities for education and setting professional standards has received little criticism and

quite a bit of praise. Criticism has overwhelmingly been directed against the way the GMC investigates and prosecutes fitness to practise cases. Yet the report recommends that the GMC should lose the first set of responsibilities and retain the second.

Donaldson recommends transfer of responsibility for setting the medical undergraduate curriculum, approving medical schools, and for the Professional Linguistics Assessment Board to the Postgraduate Medical Education and Training Board. This

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