Analysis and comment

Good Doctors, Safer Patients

Reactions to the chief medical officer's report

Last week we reported on the background and the reactions to Liam Donaldson's report, *Good Doctors, Safer Patients*, which recommends broad changes to the regulation of the medical profession. This week, we hear from a variety of people and organisations affected by the proposals.

Success relies on winning hearts and minds

Donald Irvine

Professor Sir Liam Donaldson's report¹ offers a realistic possibility that, for the first time, every patient in the United Kingdom will have the guarantee of a good doctor.² This is not only achievable and the right thing to do, but overdue. Its proper implementation would be a huge step forward for the public and the medical profession.

To achieve this objective there are two main priorities. The first is to secure doctors' wholehearted commitment to a standards based, patient centred culture of medical professionalism and medical regulation.³ This will need a General Medical Council that is vigorously proactive and that thinks and acts very differently from how it does at present. It must have new terms of reference through which it can be held to account by parliament. These must spell out the GMC's overarching responsibility for making sure that every doctor with an unrestricted licence to practise is a good doctor. This implies a different kind of council with serious expertise in, for example, the best ways of internalising professional standards across the profession, communicating its message, medical ethical issues, assessing patients' experience of their doctor's practice, the generic data requirements and assessment methods needed for revalidation, and the epidemiology of dysfunctional practice. And it means exercising creative oversight of the whole of medical education.

New beginnings

Dame Janet Smith's criticisms of the GMC,⁴ and the public's and the profession's loss of confidence in it, will make it virtually impossible for the existing council to make the necessary cultural transformation, even if it wants to try. It needs a fresh start. The current council needs to be disbanded and its successor re-formed with new members, both medical and lay, all of whom believe passionately in putting patients first through the new professionalism. The small medical majority should be retained. The authority appointing members must be independent, particularly of the NHS. As Dame Janet said, any remaining ideas of the GMC as yet another doctors' representative body need to be dispelled. The BMA does that.

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Will Donaldson's report guarantee all patients a good doctor?

Revalidation

The second main priority is revalidation. This will shift the historical focus of regulation away from entry to practice and complaints, on to the standards of the practice of individual doctors throughout their professional lifetime. Donaldson's twin track approach to revalidation through relicensure and recertification offers an imaginative way of securing the basic guarantees that the public want while giving the royal colleges and specialist societies a huge opportunity to put their own stamp on the recertification process. They can customise the generic standards, data requirements, and assessment methods to their specialty.

Who will set the standards? It will be the GMC and the royal colleges together. But the GMC must carry the ultimate responsibility, and be accountable, because it is the licensing and certifying body. The GMC's track record in developing professional standards is good. Internationally, it led the way among medical regulators when *Good Medical Practice* was first developed. With the excellent fourth edition, just published,⁵ the GMC's standards committee has shown how professional it is at managing the synthesising process, ensuring full public involvement and writing with admirable clarity.

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.

- 1 Chief Medical Officer. *Good doctors, safer patients*. London: Department of Health, 2006.
- 2 Irvine DH. Patients, professionalism, and revalidation. *BMJ* 2005;330:1265-8.
- 3 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. London: RCP, 2005.
- 4 Shipman Inquiry. *Safeguarding patients: lessons from the past, proposals for the future* [chair Dame Janet Smith]. London: Stationery Office, 2004.
- 5 General Medical Council. *Good medical practice*. 4th ed. London: GMC, 2006.
- 6 Coulter A. What do patients and the public want from primary care? *BMJ* 2005;331:1199-201.
- 7 Chisholm A, Cairncross L, Askham J. *Setting standards: the views of patients and members of the public on the standards of care and practice they expect from doctors*. Oxford: Picker Institute Europe, 2006.

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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