GMC and the future of revalidation

Time for radical reform

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Changes to UK professional regulation have lacked strategic direction. The current reviews offer an opportunity for fundamental reform that can regain public confidence

Editorial by Norcini

This is the last in a series of articles examining regulation of doctors

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BMJ 2005;330:1504-6

Despite substantial reform of the regulatory systems for UK healthcare professionals over the past decade,¹ public and political faith in the professions and their regulators is lower than ever before. In part this results from authoritative criticism in several public inquiries²—most notably the Bristol and Shipman inquiry reports.^{3 4} But another factor has been the constant litany of apparent failure to deal with incompetence, serious dishonesty, sexual misconduct, and unchecked wrongdoing such as the cases of Richard Neale,⁵ Clifford Ayling,⁶ Rodney Ledward,⁷ Peter Green,⁸ and Dick van Velzen.⁹ Recent legal reforms created a new Council for Healthcare Regulatory Excellence to oversee the regulators. The council has the power to refer regulators' decisions on fitness to practise that it regards as unduly lenient to the High Court for review. This process has also thrown up a series of apparent failures of professional regulation that do little to build public confidence.¹⁰

The changes to professional regulation have been painfully slow (see box). Progress has often been achieved only in the face of considerable resistance from powerful professional lobbies.¹¹ Yet, as the Shipman inquiry's comprehensive critique of medical regulation shows, much remains to be done. In the wake of the Shipman inquiry, the Department of Health has established not one but two reviews to explore the further reform of medical regulation¹² and non-medical professional regulation.¹³ More change now seems likely, but what form should those changes take and what can we learn from the process of regulatory reform to date?

Strategy for reform

The changes to professional regulation mapped out in the box show an incremental and piecemeal approach to reform, lacking in any sense of wider vision or strategic direction. They are a collection of essentially reactive and short term solutions to immediate problems, often made in the context of a single professional group without reference to other professions. There has been no attempt at a strategic and fundamental reassessment of the place of professional regulation in modern health services that takes into account the changing nature of health care and the professions themselves,¹⁴ new societal expectations of professional accountability,¹⁵ international innovations and experience in health professions regulation,¹⁶ and lessons from regulation in other settings.¹⁷ Such a fundamental reassessment is now long overdue. We believe it should consider four main issues:

- Harmonising professional regulation
- Defining the scope of professional practice explicitly
- Maintaining actual professional competence more rigorously

The roles of different professional groups are increasingly overlapping

- Improving the governance and accountability of the health professions.

Harmonisation

The statutory powers, administrative processes, decision making mechanisms, and resultant outcomes vary enormously across the nine bodies that regulate the health professions in the United Kingdom.¹ The regulators have different standards of evidence, different definitions of what constitutes misconduct or poor performance, different sanctions available to them, different investigation processes, and different panel arrangements. The resulting decisions are inevitably sometimes unfair and inconsistent.

The Shipman inquiry has already made the case for taking the adjudication of fitness to practise away from the individual regulatory bodies.⁴ The report argued that this function should be put in the hands of an independent tribunal service that would be staffed and trained more rigorously and consistently. But that could be just the first step in a process of harmonisation, in which common standards for managing professionals' competence and fitness to practise would be developed and used across all professions. Although particular professional groups may have some distinctive issues, there seems no logical reason why they should not use common standards, processes, sanctions, and panel arrangements; and there are many reasons to do with fairness and consistency why they should.

This process of harmonisation, once started, would be hard to stop. It would soon call into question whether we need nine separate regulatory bodies and whether greater integration into either a single regulator or a small number of regulators for groups of professions (a model already tested through the Health Professions Council) would do the job more effectively and efficiently.

Definition of roles

We currently define our professions by title—doctor, nurse, physiotherapist, pharmacist—and protect those titles in law so that unregistered people cannot use them. But we have almost nothing to say what each profession does (or cannot do). The process for joining a profession is usually expressed in terms of inputs—what education or training is expected—rather than in terms of the competencies required of a registered practitioner. There have always been some practitioners who have dual registration—dentists who are also doctors, for example—but the overlap between the different regulators is now growing. As new roles are created—nurse anaesthetists, dental technicians and hygienists, emergency care practitioners, radiology assistants, pharmaceutical assistants, etc—it is increasingly difficult to determine which regulatory body should regulate which group and to ensure a clear understanding of the functions, competencies, and training that each role entails.

A more rational but radically different model is to regulate not the professional title but the acts that a practitioner can undertake.¹⁶ This means defining an explicit scope of practice for each professional group, founded on a common set of regulated acts (diagnosis, investigation, prescribing, surgical intervention, etc). Each group would have a detailed definition of the acts practitioners can undertake and hence of the competencies they must have. When new professional groups arise, the question of whether they should be regulated is easily dealt with by examining whether they undertake regulated acts. When a group wishes to extend its role, it is again more straightforward to define the regulated acts this entails and, consequently, the competencies that need to be acquired and assessed. The question of who regulates a group becomes less important when the scope of practice is explicitly defined in a common terminology and when common standards for managing competence and fitness to practise are in place.

Continuing competence

It is now clearly unacceptable to society that health professionals qualifying in their 20s should remain registered for 40 or 50 years with no attempt to ensure they remain competent. However, none of the regulatory bodies has yet put in place an effective mechanism for assessing competence over time and dealing with suboptimal performance. Many have some requirements for continuing professional development or education, but this is no indicator of real clinical capacity or capability. The General Medical Council's revalidation proposals, which were much touted as an "MOT for doctors" are now on hold, having been revealed to be nothing of the kind.⁴

A genuine test of clinical competence must be put in place for all healthcare professionals. This could be based around the explicit scope of practice and defined competencies described above. It should be sufficiently flexible to respond to organisational context and evidence of performance, so that professionals who give cause for concern are monitored more intensively and that the arrangements of healthcare organisations with regular appraisal mechanisms complement the process of assessing competence. But, fundamentally, it must be a real examination of actual clinical competence and not some substitute or dubious proxy.

Professional regulatory reform in the UK: a brief chronology

1995

GMC publishes first edition of *Good Medical Practice*, setting out the duties of a doctor

Medical (Professional Performance) Act 1995 passed, giving the GMC new powers to deal with problems of poor performance

1999

Health Act gives the government powers to reform professional regulation through statutory Section 60 orders without the need to pass new primary legislation

Department of Health publishes *Supporting Doctors, Protecting Patients*, which calls for a fundamental review of professional self regulation and sets out 17 principles

2000

Medical Act (Amendment) Order approved allowing GMC powers to make interim suspensions, restricting restoration of erased doctors, and widening membership of conduct committees

NHS Plan outlines the intent to establish a UK Council for Health Care Regulators for the formal coordination of professional regulatory bodies

2001

Bristol Royal Infirmary inquiry recommends creation of a body to oversee professional self regulation and Department of Health publishes proposals for such reforms in *Modernising Regulation in the Health Professions*

General Social Care Council established through the Care Standards Act 2000 to regulate the social care workforce

General Dental Council reforms its governance and structure and introduces plans to regulate other professions in the dental team such as hygienists, therapists, and technicians and to make continuing professional development mandatory

2002

Replacement of the United Kingdom Central Council as the regulatory body for nurses and midwives by the Nursing and Midwifery Council and replacement of the Council for Professions Supplementary to Medicine by the Health Professions Council

Passage of the NHS Reform and Health Professions Act 2002, creating the Council for the Regulation of Health Professions (CHRP) with statutory powers of oversight over the regulators

Medical Act (Amendment) Order 2002 approved enabling introduction of revalidation, new fitness to practise procedures, and changes in governance for GMC

2003

CHRP (now known as the Council for Healthcare Regulatory Excellence) established and starts its first work programme, including performance reviews of all regulatory bodies and development of guidance on how to use its statutory powers

2004

First referrals of some regulators' fitness to practise decisions to the Appeal Court on grounds of undue leniency. Appeal Court changes some decisions and refers some others back to the regulatory body for reconsideration

Introduction of regulation for operating department practitioners by the Health Professions Council

GMC introduces new fitness to practise rules with a single complaints process to replace separate conduct, performance, and health proceedings

Shipman Inquiry fifth report extensively reviews both old and new GMC fitness to practise procedures and criticises GMC for failing to protect the public and instead acting in the interests of doctors

Department of Health consults on proposals to establish a new regulatory body for complementary therapies, initially focused on acupuncture and herbal medicine

Department of Health consults on proposals to extend statutory regulation to all healthcare support staff (paralleling the regulation of social care workers by the General Social Care Council)

2005

Department of Health suspends adoption of new revalidation procedures by GMC and announces two reviews of medical and non-medical professional regulation

Summary points

Reforms to professional regulation in the UK have been too slow and piecemeal and have lacked an overall vision and strategic direction

The nine regulatory bodies need greater harmonisation and consistency in their approach

Definitions of roles should rely on function and required competencies rather than titles

A true test of competence is needed for all healthcare professionals

Regulatory bodies should be primarily appointed to ensure that a range of stakeholders are represented and to avoid conflicts of interest

Governance

The governance of the health professions, and of their regulators, needs to be reformed to meet modern standards of accountability and transparency. As Dame Janet Smith has pointed out in the case of the GMC, it is unacceptable for the regulators to be run by boards or councils dominated by the professionals themselves, elected by their peers, and with weak, internally appointed lay membership (where “lay” can just mean someone from another health profession).⁴ The elected nature of regulators’ governing bodies creates a fundamental conflict of interest between serving the electoral constituency of members and serving the primary mission of the regulator—that is, public protection. This conflict is accentuated when council members also have other roles in trade unions or trade associations, such as the British Medical Association or the Royal College of Nursing. It is brought sharply into focus when reforms to professional regulation are brought forward, and elected councils prioritise professional self interest over public protection and act to block or water down those reforms.¹⁸

The regulatory bodies for the health professions should be run by councils that are primarily appointed. Appointments should be designed to ensure representation of a wide range of stakeholder interests but to avoid dominance by any one group, including the profession itself. The process should be run by an independent public appointments commission using explicit criteria and role descriptions and should be open and competitive. Lay or public members of such councils should not be members of any other healthcare profession. An explicit conflict of interest policy should be adopted, which would debar from membership those who hold other roles in organisations that are involved in representing or defending members of the health professions against the regulatory body or promoting the profession. The resulting councils would be far better placed to act as guardians of the public interest and much less likely to be driven by the concerns of professional self interest.

Next steps

Much now depends on the outcome of the two government reviews into regulation. They could just be further exercises in piecemeal reform, patching up the

inadequate and outdated current machinery of professional regulation so that it can limp on until there is another crisis, another inquiry, and more recommendations. We hope, instead, they are a real opportunity for fundamental and far reaching reform, aimed at creating a system of professional regulation that could command public confidence and be fit for purpose into the future. The government has most of the statutory powers it needs to enact such reforms already, through the Health Act 1999. Nevertheless, these changes might be best served by new, dedicated primary legislation to replace the messy, overlapping, and much amended legislation that currently exists.¹

The crucial question is not whether reform is long overdue but whether the political will exists to embark on such a wholesale reform of professional regulation. Some vested interests in the health professions and the existing regulatory bodies would almost certainly resist some of these reforms vigorously, but we believe that recognition is growing of the need for radical change rather than more tinkering with the status quo.

We thank Richard Baker, Aneez Esmail, and Chris Ham for their comments and suggestions for improvements to this article.

Contributors and sources: KW has a longstanding research interest in quality and performance improvement in health care, and KW and LB have researched the impact of regulation on the performance of healthcare organisations and the development of new professional roles and ways of working in the NHS. Competing interests: KW is an appointed public (lay) member of the Council for Healthcare Regulatory Excellence. This paper is written in a personal capacity and does not reflect the views of the council.

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