

abuse. The fact that seven infants had been previously abused shows that measures taken to protect them after their earlier abuse had been inadequate. An earlier opportunity to make the diagnosis had probably been missed in at least some of the six infants who had previously been admitted with drowsiness and lethargy. Three infants were apparently considered by those caring for them not to have been abused despite not having been adequately investigated. This paper thus provides evidence that British paediatricians are sometimes not diagnosing child abuse even when investigation shows that the diagnosis seems inescapable. These failures are important. If we do not recognise child abuse no action will be taken to protect the child and the child's siblings from further assaults.

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Regulation of doctors and the Bristol inquiry

Both need to be credible to both the public and doctors

Education and debate
pp 1577, 1579

Letters p 1592

Personal view p 1600

Doctors in Britain have been insufficiently regulated for too long. It has been too easy for doctors to sink into poor and dangerous performance without anybody doing anything. Now—in response to a storm of publicity about bad doctors—we may be in danger of overregulation. The dangers of overregulation may be less obvious than those of underregulation, but in the long run they may be just as damaging.

We contribute to the publicity storm today by publishing an account by a doctor who was appointed to the public inquiry into the case of inadequate cardiothoracic services for children in Bristol and then unceremoniously dumped for unconvincing, possibly political, reasons (p 1577).¹ In the current climate it's especially important that the inquiry has the confidence of the medical profession—and that probably means having a doctor as a member.

The question of whether the Bristol inquiry should include a doctor arises as the intensity of the debate over the regulation of doctors increases exponentially. The General Medical Council took a century and a half to introduce last year a system for responding to poorly performing doctors.² Proliferating reports of dangerous doctors caused the last government to produce—embarrassingly slowly—guidance on poorly performing doctors.³ But in its declining years that government had no stomach for a battle with the profession over self regulation. What's more, a new reforming president was elected by the GMC, regaining the initiative. But the Labour government elected in 1997, driven by focus groups, had to pay attention to media reports on poorly performing doctors when producing its proposals on NHS reform. The result is that self regulation is now viewed as part of a complex system of

ensuring good performance that includes (in England at least) the National Institute for Clinical Excellence, the Commission for Health Improvement, clinical governance, continuing professional development, and compulsory audit.⁴ The system is being assembled, but how it will work is far from clear.

Then Bristol struck. Everything, the *BMJ* argued, changed utterly.⁵ The GMC found three Bristol doctors guilty of serious professional misconduct and struck off two.⁶ The secretary of state announced a public inquiry and claimed that all three doctors should have been struck off.⁷ The profession went into overdrive to produce overdue reform, particularly in local self regulation.⁸ The GMC came up with the idea of revalidation.⁹ Meanwhile, media stories have appeared almost daily on "rogue doctors" and "butcher surgeons."¹⁰ The government has had no choice but to "do something," and the Queen's speech hinted at emergency powers to protect patients.¹¹ The government also thinks that it has to have the power to change rapidly the laws governing professional bodies like the GMC. The worry for the profession is that such powers may lead to reform being politically rather than professionally led.¹²

It's against this background that the Bristol inquiry has begun and will start its public hearings after Christmas (www.Bristol-Inquiry.org.uk). Opinion in the city, and across the country, is deeply divided between those who believe that the doctors have been made into scapegoats by the GMC to ensure its survival and those who think that the delay in taking effective action was scandalous. Some believe that the inquiry has an agenda to abolish self regulation. Rumour and counter-rumour are rife, and the inquiry will have a tough job.

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There are two strong arguments for including a doctor, preferably a surgeon, on the inquiry: understanding and credibility. Juries include no experts, yet sit in judgment on the most complex and awful crimes—but this is no crime. Those who put their fingers into the hearts and brains of others to try and save their lives are qualitatively different from those who don't: it requires a special kind of courage and a mixture of compassion and detachment that most find difficult to muster. Only another surgeon can understand fully the difficulties that the Bristol surgeons faced.

To succeed in its mission to understand, explain, and improve the public inquiry will have to command the credibility of all parties. The GMC clearly failed, as views expressed in this issue show (p 1579, 1592),^{13 14} and the inquiry may have an almost impossible task—because it starts in a climate of deep division and bitterness. The inquiry will lose the credibility of many, probably most, doctors if it starts without a doctor on the panel. The difficult challenge is to find a doctor who is not seen as a stooge of the establishments of either medicine or the Department of Health.

Meanwhile, the government and the medical profession want to restore the public's confidence in the competence of doctors and the quality of care within the NHS. They must achieve this against a flood of adverse media reports, which makes careful thought difficult and increases the pressure to do something, no matter how hasty and ill considered.

What might the perfect system look like? One long philosophical tradition, represented best perhaps by Thomas Hobbes, believes that people are essentially bad and need to be tightly regulated to stop them doing ill. Another tradition, represented by John Locke, believes that people perform best if trusted, given space and resources, and essentially left to their own devices. Hobbesians might favour government control of doctors, Lockeians self regulation. Probably a mix is needed and a wider concept of self regulation

that includes good management.¹⁵ Perhaps we are headed in the right direction with a re-energised GMC with heavy lay representation and the new systems of clinical governance. The danger is, however, that it's all too much and too confused. Doctors now face revalidation, compulsory continuing medical education and audit, governance of their clinical activity by their trust or primary care group, peer review, and a possible visit from a hit squad from their college or from the Commission for Health Improvement. The dangers are that their internal motivation (the most important thing) is crushed, that their time is diverted into activities that are more bureaucratic than beneficial to patients, and that they resort to game playing to buck the system (something at which doctors are highly skilled). Out of this muddle doctors and politicians must produce a more coherent system of regulation and governance that is credible to both patients and doctors.

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The end of the heparin pump?

Low molecular weight heparin has many advantages over unfractionated heparin

Antithrombotic therapy with intravenous unfractionated heparin has been the mainstay of early treatment of patients with venous thromboembolic disease and unstable angina. On a typical medical ward several patients will be attached to syringe drivers containing heparin. Management of these patients is time consuming: heparin infusions have to be made up daily, intravenous cannulas resited, blood samples analysed for monitoring of coagulation control, and doses adjusted on the basis of these results. The potential for dosing errors is high: even in trials with criteria for dose monitoring, over 60% of patients are overanticoagulated or underanticoagulated 24 hours after the start of heparin therapy.¹ Newer low molecular weight heparins are much easier to administer, but do they have other advantages over unfractionated heparin?

The benefit of heparin treatment to patients with venous thromboembolic disease and unstable angina has been shown in several trials. In the only placebo controlled trial of heparin in pulmonary embolism the mortality rate was so much lower in treated patients that the trial was stopped.² In unstable angina several randomised trials have indicated a trend towards reduced risk of death and non-fatal myocardial infarction in patients treated with aspirin and heparin compared with aspirin alone. A meta-analysis of these trials indicated a relative risk reduction of 33% with combined aspirin and heparin in patients whose absolute risk of death or myocardial infarction is 14% in the first three months.³

Conventional unfractionated heparin refers to a family of mucopolysaccharides of varying chain length and composition which are not separated into

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