eased through honest discussion of the match between doctors' expectations and organisational and societal needs. It is also worth remembering that many doctors are happy and it will be important to ensure that they are fully engaged in helping to develop solutions.

More discussion and research are required to understand this problem and its possible solutions in more detail. In the meantime there is a key role for leaders in the medical profession nationally and in hospitals and primary care to work together with NHS managers to develop a new compact that improves care for patients, improves the effectiveness of the healthcare organisation, and helps create a happier workforce.

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The medical profession, the public, and the government

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The old implicit compact between doctors, patients, and society has broken. Chris Ham and George Alberti want to write a new one

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The world is changing rapidly—probably more so than at any time since the industrial revolution. This applies to the professions as much as any other sector of society. So how has the medical profession altered and how is it responding to these societal pressures?

In the 19th and early part of the 20th century British physicians were private practitioners and functioned independently. There was a strong moral and ethical background to medicine and a tradition of voluntary work in the poor law institutions as well as in the community. Self regulation began in the 16th century with the foundation of the Royal College of Physicians. This functioned both as a setter of standards and as a closed shop. The Royal College of Surgeons followed two centuries later.

Learning at that time was based on a few medical schools and an apprenticeship system. Self regulation and a more uniform educational approach were strengthened in the 19th century with the establishment of the General Medical Council (GMC) and the introduction of royal college examinations. Throughout this period, standards and quality were implicit rather than explicit, with government and society trusting the medical profession to protect the public and granting the profession considerable autonomy in the process.

The implicit compact

The introduction of the NHS in 1948 did not fundamentally alter the commitment to medical autonomy and self regulation, but it did result in a new relationship developing between the government, the medical profession, and the public. This relationship was underpinned by an implicit compact based on:

- The government guaranteeing access to care for all citizens and determining the budget for the NHS
- The medical profession taking responsibility for ensuring clinical standards and delivering care to patients
- The public accepting its healthcare rights from the government, delivered to appropriate standards by the profession, and paying taxes to fund the NHS.

Summary points

The NHS was established on the basis of an implicit compact between the government, the medical profession, and the public

This implicit compact has been undermined over the years and needs to be updated

A new compact is needed spelling out the rights and responsibilities of the government, the medical profession, and the public

This will not be easy to agree but is essential to enable the different partners to make an effective contribution to the reform of the NHS

As Klein has pointed out, part of the implicit compact was the government granting the medical profession a large measure of autonomy and control over its work.[1] In return, doctors accepted the right of government to determine the budget and the broad national policy framework. It followed that doctors took decisions on the priority for treating patients within the available budget (rationing) and politicians did not seek to influence these decisions. In other words, there was a degree of collusion between the government and the medical profession about not interfering in each other's sphere of responsibility.

One of the consequences was that medicine continued to be largely self regulating, with both government and the public ceding to the profession the responsibility to control standards and assure quality through the GMC and royal colleges. The years after the establishment of the NHS were also the age in which managers were administrators and saw their job as providing the resources and environment in which doctors could do the job that they (the doctors) defined to be appropriate. Patients were passive recipients of care and were usually willing to accept that "doctor knows best."

The weakening of the implicit compact

Pinpointing exactly when the implicit compact began to weaken is hard, but the 1960s were probably the watershed. Around this time several things happened.

(1) Organisations representing patients became a more important and challenging force. Examples include the Patients' Association, the National Association of Mental Health (MIND), and the National Association for the Welfare of Children in Hospital.[2]

(2) Evidence began to emerge that standards were not always up to scratch. Initially this evidence emerged from independent investigations like *Sans Everything: A Case to Answer*,[3] a report highlighting low standards of care for elderly patients. But these investigations were quickly followed by official inquiries, such as the inquiry into conditions at Ely Hospital,[4] an institution for people with learning difficulties.

(3) The medical profession became increasingly demanding and started lobbying the government for increases in the NHS budget as technical advances enabled doctors to do more for patients. This began with an argument for greater capital investment[5] but developed into sustained campaigning for additional revenue.

The next 30 years witnessed a variety of incremental changes that taken together brought into question the assumptions on which the implicit compact was based. These included:

(1) Attempts to give patients and the public a stronger voice in the NHS—starting with the introduction in 1974 of community health councils as statutory bodies responsible for representing the public's interest in the NHS

(2) Moves to strengthen controls over standards—for example, the setting up in 1968 of the Hospital Advisory Service, a kind of forerunner of the Commission for Health Improvement, in response to the report on Ely Hospital

(3) The introduction of clinical audit as a way of getting professionals to review their work—but on a voluntary basis. This built on patchy initiatives taken by the profession itself

(4) Policies to involve professionals in management—for example, as in the recommendations of the Griffiths inquiry into NHS management in 1983.

From gentle administration to hard nosed management

At this time, in the wake of the oil shocks of the 1970s, governments became much more active in seeking efficiency improvements in the NHS. Among other things, gentle administration was changing to hard nosed management, budgets had to be justified, and costs were becoming a real part of the equation. This led to strained relationships between managers seeking greater productivity and doctors feeling they were doing all that could be done with the available resources. The result was to undermine doctors' sense of professionalism and to reinforce the feeling that they were on a conveyor belt in which the number of patients seen mattered more than the quality of care. Subsequent events have strengthened this feeling and at worst have resulted in alienation between managers and doctors.

The door to the secret garden starts to open

Notwithstanding these developments and the emergence of voices within the profession questioning whether clinical freedom still existed,[6] doctors were still self regulating and enjoyed much autonomy. Neither government nor managers saw their role as challenging medical dominance over clinical decision making, which remained largely a secret garden exempt from scrutiny. None the less the medical profession did not stand still. Postgraduate education was strengthened—starting with general practice—and doctors were better trained than ever before. The need for explicit standards was slowly being recognised, as was the expectation that doctors should be more accountable for their performance.

More enlightened members of the profession also took steps to involve patients and their representatives in decision making, for example through patient participation groups in primary care and through initiatives on shared decision making. This was in response to a steady decline in deference and a greater

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Prominent system failings—like the Bristol paediatric cardiac surgery scandal—have helped weaken the compact

willingness on the part of the public to question professional decisions.

The public also began to have higher expectations of public services and to challenge whether the money they were paying in taxes was being spent wisely. Rising expectations were fuelled by increasing affluence and a widening gap between people's experiences in other sectors of consumption and public services. Politicians responded by opening up a debate about the size of public spending and the scope for cutting taxes to enable the public to make more choices themselves.

The end of the implicit compact

These developments have accelerated since 1997, when arguably there has been more change than in the previous 49 years. In effect, the implicit compact between the government, the public, and the profession has been undermined in the process. Building on the trends we have described, this period saw:

(1) The emergence of groups of the public who are more demanding, less deferential, more vociferous, and more aware of the likelihood that things may go wrong

(2) A public made more knowledgeable through the internet and media, with information no longer the secret weapon of the professional (akin to the impact on the clergy of the translation of the Bible from Latin to English)

(3) An increasingly litigious culture and lack of understanding of or proper explanation of risk by the profession

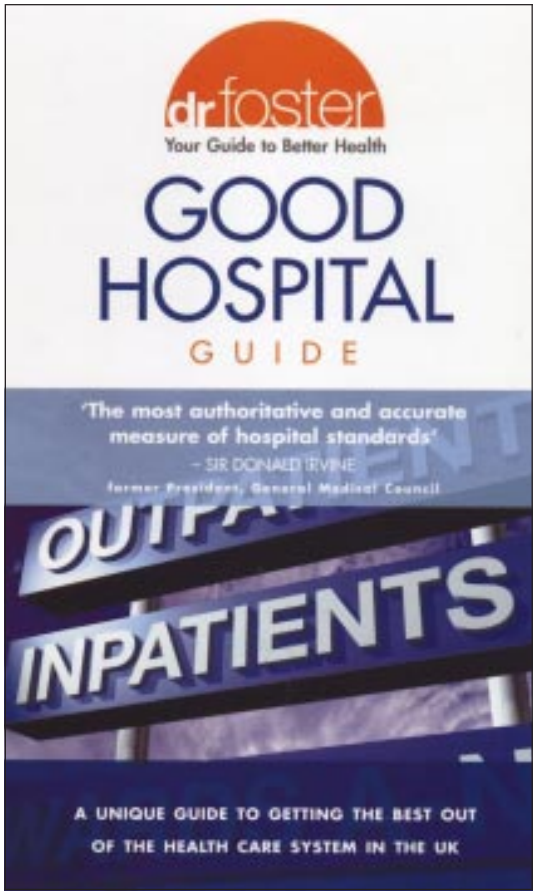
(4) Well publicised evidence of failures of clinical performance at both individual and organisational levels such as the retention of organs without consent at Alder Hey Hospital, the deaths of children after heart surgery at Bristol, and the murder of patients by the general practitioner Harold Shipman

(5) A strong challenge to self regulation by the government, the informed public, and parts of the profession

(6) A greater willingness on the part of government itself to become involved in issues of quality and to regulate performance and standards.

These developments help to explain some of the current discomfort and discontent in the medical profession because their effect is simultaneously to increase the accountability of doctors and to reduce the esteem in which the profession has traditionally been held (although public surveys indicate this is still high).

The challenges facing doctors are exacerbated by increasing workloads and frustration at the growing gap between what it is possible to do for patients and what can be done with available resources, even with the additional funding made available to the NHS in recent years. This frustration is accentuated by the increasing internationalisation of medicine and the use of benchmarks from other countries to show areas in which the United Kingdom is falling behind what is achieved elsewhere. Having made this point, it is also clear that doctors are unhappy almost everywhere[7] as health care systems across the world find themselves under increasing pressure.



Patients and public want more information and more transparency

A new and explicit compact

If the implicit compact has been undermined, then what might be the basis of a new one?

Patients' rights—For the public, it is important to recognise that patients see themselves as having rights and expect the same standard of service in the NHS as in other sectors. This means accepting the legitimacy of rising societal expectations and enabling the NHS to meet these expectations through sustained increases in resources.

Public responsibilities—At the same time, there has to be recognition that the NHS is not a market in which consumers shop around for treatment and care. In a cash limited and cash constrained NHS there are limits on patients' rights and also responsibilities on the part of the public to use services appropriately and to contribute to the well being of others, for example through blood donation. For their part, patients have a responsibility to treat doctors and other professionals with dignity and respect[8] and contribute to their own health by adopting appropriate lifestyles and acting on the professional advice they are given.

Greater accountability—For the medical profession, the new compact has to involve acknowledgment that self regulation must be strengthened[9] and supplemented by the work of new forms of audit and review like the Commission for Health Improvement and the National Clinical Assessment Authority. Increased accountability is essential to preserve appropriate discretion and autonomy and to avoid doctors becom-

ing mere technicians, slavishly following rules and regulations determined by others. Equally, the profession has to accept the legitimate role of managers in the NHS while being willing to play their part in steering the system at all levels.

Enough resources—In return, it is reasonable for doctors to expect government and managers to provide them with the resources they need to deliver a high quality service. This includes providing resources to enable doctors' working lives to be improved through administrative support, opportunities for career development, and recognition of the role of the profession both through pay and other means. Of particular importance is the need to ensure appropriate training opportunities and flexibility to accommodate the increasing number of women in medicine and the need to allow doctors to take on different roles towards the end of their careers.

Partnerships—The quid pro quo is that doctors have to treat patients with dignity and respect and to see them as partners in the process of decision making and care giving through informed consent and other mechanisms. There is also a need to accept the legitimacy of moves to increase patient and public involvement in the NHS. All of this implies a new kind of professionalism in which there is a different balance between autonomy and accountability and a willingness to accept that social relationships underpinning the clinical encounter have altered irretrievably.

Support for effective care—This includes recognition of the need to strengthen the scientific basis of medicine and for government to support doctors by providing access to information and evidence to aid clinical decision making. The reality is that in a world of ever expanding research into clinical and cost effectiveness, ensuring quality cannot be left to individual clinicians. It follows that the system in which doctors practise has a responsibility to facilitate the transfer of evidence into action. In this respect, government and the profession need to work in partnership to enable patients to obtain access to the best possible care.

Stewardship—For government the new contract entails exercising stewardship of the NHS and developing a regulatory regime that gives confidence to the public and ensures effective professional accountability. In this role government has a responsibility to facilitate partnership with and between the medical profession and the public and to continue to allocate sufficient resources to enable the NHS to meet contemporary expectations. Government has a role too in encouraging a mature debate about the limits of medicine and the NHS and recognition that mistakes will occur however good the systems that are put in place. As this happens, the aim should be to move away from a blame culture to an NHS in which it is recognised that most failings result from systems failures for which all parts must accept some share of responsibility.[10 11] The other side of the coin is recognition of the continuing importance of professionalism, albeit a professionalism adapted to the 21st century.

Trust

A new compact will be agreed only if the representatives of the medical profession, the public, and government trust each other and believe they are working towards common goals. In the context of current debates this may seem hopelessly naive, but in the absence of trust it is difficult to envisage how a constructive relationship can be developed.

Trust has been strained by failures in clinical performance and the perception on the part of the profession that government has been too ready on some occasions to blame doctors when things go wrong. The trust of the public has been undermined by the tendency of government to promise more than it can deliver, a tendency that has at the same time led doctors to feel that politicians are raising public expectations to levels that cannot be met.

The new compact we have proposed offers a way forward in emphasising the rights and responsibilities of each partner and the need for realism about what can be expected of the NHS. The compact will, however, be meaningful only if there is much better communication between the medical profession, the public, and the government based on an honest understanding of each other's position. A start on this might be made by using forums like the NHS Modernisation Board that bring together different stakeholders to strengthen communication and to debate mutual expectations. Above all, behaviours and actions must be consistent with the content of a new compact to avoid a further deterioration in relationships between the medical profession, the public, and government.

Conclusion

In offering these ideas for discussion, we would reiterate that current discontents are not unique to the United Kingdom or to the medical profession. Health care systems throughout the world reflect the societies and values in which they are embedded, and the NHS is no exception.

To return to our starting point, at a time of rapid social change it is to be expected that those involved in funding, providing, and receiving services as important as health care should be reflecting on how roles and relationships need themselves to change.

As this debate develops, all those involved should play their part, including other health professions, whose contribution to care giving is more important than ever. In an era of team working, medicine can no longer stand above and on one side from the collective responsibility to deliver high standards of care, even though the role of medicine among the health professions remains pre-eminent. Many do not wish to—but for others it is time to stop grieving for the past and to meet the challenges of the new world and the future. To be sure, the difficulty for the medical profession in acting in a concerted way in this debate is formidable,[12] given the wide range of bodies like the BMA and the royal colleges that speak for doctors, but the risk in not doing so is even greater.

The authors write in a personal capacity and their views are not necessarily those of their organisations.

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From guidance to practice: Why NICE is not enough

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The National Institute for Clinical Excellence (NICE) has an important role in providing the NHS with consistent and timely guidance on what is best for patients. However, it can fulfil its promise only if its products are implemented within a system which supports the changes that NICE promotes. At present, this is not the case. We consider what NICE needs to succeed and how its chances could be improved.

Summary points

The National Institute for Clinical Excellence (NICE) can fulfil its promise only if its guidance is implemented by a health service that supports the changes that NICE promotes

At present, this is not the case: there is ambiguity about how NICE reaches its conclusions and uncertainty about the impact of guidance on the NHS and about who monitors compliance

As a result, NICE's impact is uncertain and geographical inequity in the provision of health services is likely to persist

Debate and clarification of these issues would give NICE a better chance of benefiting patients and strengthening the NHS

How does NICE work?

NICE was generally welcomed on its inauguration.[1 2] Previously, a lack of capacity at national level to appraise healthcare interventions before, or indeed after, their widespread diffusion had several adverse consequences: no guidance was available when important new drugs were first marketed, local policies varied, and unproved interventions entered routine use.[3] NICE filled this gap, giving guidance on interventions of uncertain value and providing clinical guidelines and clinical audit packages. NICE should be congratulated for the transparency it has shown in its processes, in the face of some opposition from the pharmaceutical industry.

NICE's decisions are based on an assessment of the technology, usually prepared by independent researchers commissioned by the Health Technology Assessment programme, and submissions from the manufacturer(s) and from patient and professional groups. These are considered by the appraisals committee, which then advises the institute on what the guidance to the NHS should be. This follows two periods of consultation, and consultees may appeal as a last step before the guidance is issued to the NHS.[4] The table summarises NICE's guidance to date.

How successful has NICE been?

NICE has succeeded in executing a complex and high profile process that has changed the terms of debate about the interventions it has reviewed. There is now a broad acceptance in principle of the legitimacy of central guidance on controversial issues of service availability, even if specific pieces of guidance are not unanimously supported. Yet the real measure of NICE's success should be an improvement in the overall cost effectiveness and appropriateness of the interventions available to the NHS's users. There is as yet no published information on the implementation by the NHS of NICE's guidance, so we cannot assess success against this yardstick. Sharp criticism[5 6] indicates that NICE's honeymoon period is long since over and that there is, or will be, resistance to implementation of pieces of guidance that are particularly expensive or clinically unpersuasive. Before condemning NICE, we should examine how much of the difficulty arises from NICE itself and how much from the context in which it must work.

For NICE to achieve its goal of improving the appropriateness of healthcare interventions available in the NHS, there should be clear answers to three questions.

- How does NICE reach its conclusions? The NHS will be more likely to implement NICE's guidance with confidence if it understands the guidance's origins
- How is the NHS to respond to NICE guidance? Uncertainty about the impact of guidance will make planning and delivering clinical services more difficult
- Who monitors compliance with NICE's guidance? Without checks on compliance, there can be little certainty of NICE's impact nor feedback on the effectiveness and acceptability of its products.

How does NICE reach its conclusions?

NICE was preceded by various regional bodies, such as those in the South and West[7] and Trent.[8] These showed that it was feasible to evaluate healthcare interventions quickly enough to satisfy the NHS but rigorously