Good doctors: safer patients—the Chief Medical Officer's prescription for regulating doctors

The Chief Medical Officer, Sir Liam Donaldson, has recently published his recommendations[1] on how the government should respond to the serious criticisms of medical regulation and the General Medical Council made by Dame Janet Smith in her final report of the Shipman Inquiry.[2] In a thoughtful and well-written report, he places the regulation of doctors within the wider set of systems for improving and quality assuring modern practice. Doctoring is at the heart of the healthcare system. Sir Liam's focus throughout is, therefore, on how to make sure that in future everyone in the UK who needs a doctor gets a good doctor.[3] It means that patients should feel they can trust any doctor without even having to think about it,[2] and that doctors themselves would entrust members of their family to any colleague without a moment's hesitation.

So how could this be achieved? The foundation is to be an agreed definition of what a good doctor is and clear, practical standards of professional practice for achieving that. These standards would be thoroughly embedded into medical registration and licensure, certification for specialist and general practice, medical education and doctors' contracts of employment. Thus, a common standard of entry to the profession would be assured through a new, standardized national examination for all doctors (irrespective of their place of primary qualification) applying for registration with the GMC for the first time. For established doctors continuing competence to practise will be assured through revalidation embracing relicensure and recertification. The management of concerns about a doctor's practice would be made fairer and more effective by placing greater emphasis on:

- retraining and rehabilitation
- a stronger GMC presence at the workplace through a GMC affiliate
- the separation of the investigation and adjudication functions in fitness to practise cases.

At all stages implementation should be systematic, using robust, evidence-based methods of clinical governance, assessment and appraisal, and with full public participation. Inevitably, in the consultation that now follows, there are important matters needing further clarification and discussion. I offer five here.

The first is about the definition of a good doctor and the standards of professional practice that should underpin it. Sir Liam makes the point that there is no universally agreed definition of a good doctor. However, there is abundant evidence that the public do know what they want—essentially doctors who are technically competent, are capable of forming and maintaining good relationships with patients and colleagues, and are honest.[4] That is why there is strong public (and international) support for the GMC's *Good Medical Practice*.[5,6] This, together with the versions adapted by the Royal Colleges for each specialty and general practice, contains everything patients think is necessary to ensure patient-centred care. It embodies the essence of doctors' professionalism.[7] It is some doctors who dispute the advice mainly to try and water it down. So the issue is really about getting greater buy-in from all doctors, whilst at the same time working with the Royal Colleges and medical educators on the generic and specialty-specific criteria and thresholds needed to make *Good Medical Practice* fully operational.

The responsibility for standards must surely rest with the GMC because it keeps the register, gives the licences to practice, and holds the specialist and general practice registers which indicate to the public who has been certificated and, in future, revalidated. A licensing body is nothing if it is not the ultimate setter and guardian of the standards—that is its foremost function.[8] Of course, the council has to work with others to get the best result. To this end the GMC Standards Committee has the infrastructure, the know-how, experience and track record of doing this well. The plain fact is that the public will hold the GMC accountable anyway, whatever the government or anybody else says. Public confusion and irritation are likely outcomes if that accountability is obscured through a diffusion of responsibility.

Sir Liam's proposals for revalidation are excellent. They reflect the foundation principles and attributes set out in the original GMC consultation document in 2000,[9] but they also take us forward to new ground. The Royal Colleges and specialist societies are to take lead responsibility for delivering the key recertification element of revalidation for their members. Here is a real opportunity for each of them to press ahead, encouraged by the kind of inspirational example of leadership given by the American physician Dr Troy Brennan.[10] Sir Liam has clearly been influenced by the regulatory philosophy and methods used in other high tech industries such as civil aviation where regular, thorough assessment is combined with strong professional development and a supportive working environment to ensure safety through both competence and high morale. At first sight the numbers in medicine are daunting—177 000 doctors compared with 17 000 airline pilots. But they should become eminently manageable if one breaks the profession down into its individual specialty constituents. For instance, there are only 350 cardiac surgeons. With

their national performance data set already established they are almost there. In general practice, the largest single branch with about 42 000 doctors in the UK, the numbers present a more formidable challenge.

The GMC, in its most recent proposals for revalidation, has favoured a light touch, risk-based approach in which the practice of some doctors would be looked at more thoroughly than others.[11] Sir Liam questions the appropriateness of this for doctors, pointing out that there is no easy way of defining all high-risk groups in medicine. 'The bottom line,' he reasons, 'is that lighter-touch regulation would mean that some ongoing risks to patients would have to be tolerated by society'. The strategy is not compatible with the concept of a guarantee to the public of a good doctor for all. It is therefore essential that the risk-based concept be clearly explained to the public during the consultation using numbers that quantify and illustrate the risk in very straightforward terms. The government will need to demonstrate that it has the public's fully informed consent if it decides to support this line. It is patients, not doctors, who may be killed or injured by poor doctoring.

Doctors are understandably anxious about the proposal to adopt the civil rather than the criminal standard of proof in fitness to practise cases. They may be helped by further explanation from the GMC or legal authorities. The civil standard was used in the past in health and performance cases. But a key point, not generally appreciated, is that the most contentious decisions are often around panel judgements involved in determining impaired fitness to practise and any actions to be taken on registration. Standard of proof is not central to these determinations. Doctors, and the public, are more likely to have confidence in future when the basis for these decisions is clearly related to the professional standards, and the reasoning behind them in individual cases is made absolutely plain and transparent.

The proposal to consolidate responsibility for medical education on the Postgraduate Medical Education and Training Board (PMETB) will be contentious because the undergraduate curriculum is a GMC success story and the PMETB is too new to have a track record on which to predict its future performance. There are clear advantages to be gained by bringing the two strands of education together. There is the added value of making the continuum of education a reality. Even more important is the concentration of educational and assessment expertise now badly needed if Britain is to stay at the leading edge in medical education. Then there is the complex set of issues around the hidden curriculum.[12] This refers to the attitudes of medical teachers and the culture of the institutions to which they belong: all of which can have a huge influence on the kind of doctors the system produces. For all these reasons, medical education has got to be tied closely to the profession's standards. Logic would suggest incorporation in the GMC. But the requirement for a new order of specialization may be better achieved through the formation of a completely new body designed specifically to meet tomorrow's educational challenge. The arguments are finely balanced. More discussion is needed.

Finally, what of the GMC itself? Sir Liam, like Dame Janet, wants the council to concentrate on doing a smaller number of things well, for its medical members to be appointed in future and for the council to act like a board of directors. I agree. The key function of a modern professional regulator is to set the standards required for practice and, through its control of the registers, to be assiduous in making sure that all who hold registration with it abide by those standards. It needs to lead a team of partners, not try to do it all itself.

The council can only do this successfully if it has members who believe passionately in the mission and who are, if they are doctors, all known and respected by other doctors as role models of the good doctoring they wish to promulgate. The role model principle should apply, incidentally, to all doctors who work for the GMC for they are in a way its ambassadors to the profession and the public. All council members, lay as well as medical, need to be tall poppies in the field capable of giving strong leadership, not least because they will have a profound impact on the organizational culture on which the success of the GMC in future will ultimately depend. Selection by an open process is more likely to achieve this result than elections which have hitherto placed undue emphasis on representation. Professionally-led regulation should therefore be strengthened.

The recent criticisms of the current GMC will make it virtually impossible for it to make the cultural transformation needed with confidence and conviction, even if it wanted to. So a line needs to be drawn. The current council needs to be disbanded and its successor re-formed with members, medical and lay, who can give it a convincing fresh start. Introducing robust accountability to Parliament should help the process of change by adding the discipline inherent in the external scrutiny of performance.

The combined effect of Sir Liam's measures could be quite profound. They should help to strengthen professionalism in medical practice, be strongly reassuring to the public and patients, and appeal to the huge majority of conscientious doctors who take pride in the good name of their profession.

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The impact of surgical care practitioners on surgical training

The emergence of surgical care practitioners over recent years is considered to be a 'mixed blessing' by the majority of specialist registrars. In the National *Curriculum Framework for Surgical Care Practitioners* document,[1] a surgical care practitioner is defined as:

> '. . . *a non-medical practitioner, working in clinical practice as a member of the extended surgical team, who performs surgical intervention, pre-operative and post-operative care under the direction and supervision of a consultant surgeon*'.

Most trainees understand that the work load of surgical teams will continue to rise in the face of falling numbers of specialist registrars and other junior doctors, and that steps must be taken to address any associated deficiency in service provision. Properly trained, suitably experienced surgical care practitioners could have an important role to play as part of the 'modern' surgical team. Surgical care practitioners would be drawn from the existing pool of nurses, operating department practitioners and allied health professionals. It is envisaged that they would have a significant role in the pre-operative assessment, examination and preparation of patients for theatre, as directed by agreed guidelines and protocols.[1] For example, the preparation by a nurse practitioner of patients for diagnostic cardiac catheterization has been demonstrated to be safe, in a randomized controlled trial, compared with the established system of preparation by a member of the junior medical staff.[2] Surgical care practitioners would also perform certain technical and operative procedures, in addition to acting as assistant to the operative surgeon.[1] The use of an appropriately trained nurse, as first assistant to an operating consultant, has not been demonstrated to compromise results in low-risk cardiac surgery cases.[3] They would be expected to play an active role in postoperative care and they would also practice within the normal out-patient department, including assessing patients.[1] The successful use of a nurse practitioner, in what amounted to a semi-independent follow-up breast clinic, has been presented in a previous issue of this journal.[4]

However, from a surgical trainee's perspective, several concerns persist, demanding attention prior to the expansion of the surgical care practitioner grade. First, surgical care practitioners should have a positive impact upon service, without diluting the already much reduced surgical exposure available to trainees. In addition, the restraints forced upon surgical training by the *European Working Time Directive* and the impact of *Modernising Medical Careers* will further truncate surgical exposure. Steps must be taken to ensure that the role does not further limit possible theatre experience. The curriculum framework document states that surgical training will not be compromised.[1] However, we have reservations that the proposed use of surgical care practitioners to support junior surgeon training sessions, or their being used to provide delegated care of patients during consultant-led training sessions, would make a significant impact on training opportunities. It is commendable that the general public insist on an increased level of surgical quality, but that is far from guaranteed if the next generation of surgeons must compete for surgical experience with other healthcare professionals. For example, it is likely that surgical care practitioners and junior surgical trainees will be trained in the same basic surgical procedures; skills that the surgical trainee will be expected to master quickly in the face of reduced surgical training. Consultant delivered training of individual surgical trainees will also suffer if consultants are made responsible for the training and subsequent supervision of surgical care practitioners. A shorter length of surgical training must be matched by an increase in quality and intensity, but a dilution of training seems the inevitable result of such competition for consultant time.

In line with medical practice, individual performances should also be scrutinized in a standardized manner. Specialist registrars are regularly assessed within the record of in-training assessment (RITA) framework to assess satisfactory progress and competence. Consultants are required to undertake continued professional development, in addition to appraisal and revalidation. The curriculum framework document[1] provides limited information concerning what will be expected, in terms of continuing professional development, and the ongoing assessment of performance, following the completion of surgical care practitioner training. If such practitioners are also to operate on patients alongside surgeons, then their ongoing professional assessments should be similarly standardized and vigorous. Perhaps such assessments should be undertaken by the same professional body.

The level of supervision under which surgical care practitioners are to work also requires clarification. It is now no longer considered acceptable for junior surgeons to operate in adjoining theatres to consultants, performing 'parallel lists'. Surely, it is therefore contradictory, and unacceptable, for surgical care practitioners with comparable or, as will often be the case, less surgical experience to operate under such a level of supervision. We feel further clarification of levels of supervision is essential.

Up to this point the concerns raised concentrate upon the perceived impact upon surgical training and performance assessment. Of equal importance is the assurance that the patients will be informed exactly who is to operate on them, as part of the process of informed consent. They should be made aware that, although properly trained to an accepted standard, surgical care practitioners are not medically qualified. Patients should be enabled to express a preference to be operated upon by a medically qualified person, without the implied perception that their subsequent care will be prejudiced, or significantly delayed.

Surgical care practitioners could have a positive impact upon various aspects of the efficiency of the surgical team. As detailed by the curriculum framework document,[1] their role could include the preoperative assessment and preparation of the patient for theatre. In addition, the organization and liaison skills of an experienced healthcare professional could ensure the smooth running of the surgical unit, with the expected benefit of enhancing the patients' perception of the service provided. [5-7] Such positive impact on service would also, in part, compensate for the removal of experienced surgical nurses from the often undervalued role of the traditional ward nurse.

On a more general note, the proposed title of those undertaking such a role is also a potentially controversial issue. The British Medical Association has noted that the term 'practitioner' (particularly when prefixed by surgical) could lead to the patient misconception that the post holder is medically qualified. They suggested that the term 'surgical assistant' should be adopted instead, in keeping with practice overseas.[8]

Although, undoubtedly, there is much careful discussion and clarification still to be done, we believe that surgical care practitioners have a potentially valuable role to play in the surgical team. Not as independent, or semi-independent, specialists performing routine operations in order to shorten waiting lists, but as healthcare professionals who can bring experience from their unique backgrounds to a well-defined role within the surgical team. Their role should not compete with established surgical practice and training: rather it should improve the patient's experience, whilst making the service more efficient.

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