Will we be getting good doctors and safer patients?

Last week, the Department of Health announced its plans for reforming regulation of UK doctors. The ***BMJ*** asked some of those affected for their opinions

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Graeme Catto, president General Medical Council, London

I believe that forward thinking doctors will welcome this white paper, which puts the uncertainties of recent years behind us. The emphasis on the independence of the General Medical Council—independent of government as the UK's dominant healthcare provider and of dominance by any single group—is right if we are to command the confidence of everyone who receives and provides health care. We all need a lasting settlement.

The white paper stems from the four major inquiries that tragically showed what can go wrong when a tiny number of doctors depart from the high standards that are rightly expected of them. Professional regulation, however, must primarily be concerned with supporting and embedding good practice; the majority of doctors are good doctors who strive to be better. Support for ill doctors is particularly welcome.

The central role of the medical register is recognised, together with the GMC's four main functions: setting standards, coordinating all stages of medical education, ensuring that only appropriately qualified doctors are registered, and dealing effectively and fairly with concerns about individual doctors. These interlocking functions remain the basis for independent professional regulation built on the GMC's accountability for the fitness for purpose of the register and fitness to practise of those on it.

The principle of revalidation, which we first suggested 10 years ago, is now accepted. We must begin relicensing and recertification as soon as practicable.

The composition of the council will be changing, with equal proportions of medical and lay members. Council members need to be there because of specific interests, competencies, and commitment to the public interest; democracy on its own will not give us the most appropriate mix. We have agreed to introduce the civil standard of proof, flexibly applied, to take account of the seriousness of the allegations and the possible consequences for the doctor. This will not result in more doctors being suspended but will enable appropriate restrictions on practice when that is necessary to protect patients.

The white paper extends our role in coordinating all stages of medical education, in defining and assuring standards of practice, and in modified plans for GMC affiliates. The further separation of adjudication is an incremental change, since we already have independent panels. Many doctors, as well as patients, have questioned whether we should both investigate and adjudicate, however well we perform the tasks.

Regulation is a dynamic process. The GMC has already made important reforms. This white paper provides a secure foundation for the GMC and for the medical profession in the years ahead.

Adam James Pringle, general practitioner, Lawley, Telford

It is sad, but unsurprising, to see the changes in medical regulation suggested in *Good Doctors, Safer Patients*[1] being railroaded through unchanged despite the almost universal agreement among working doctors that they are fundamentally flawed (doctors.net.uk discussion forum). To quote Liam Donaldson, "There is little disagreement with the assertion that in 2006 every patient is entitled to a good doctor. Yet, there is no universally agreed and widely understood definition of what a good doctor is. Nor are there standards in order to operationalise such a definition and allow it to be measured in a valid and reliable way."

The white paper proposes annual inspection of doctors. If this were a proposal to screen for a medical problem, it would fail to meet almost all of the World Health Organization criteria required to justify its introduction.[2] We do not have a definition to measure the doctors against; nor do we have any valid and reliable test that will separate the good from the bad. It is far from clear how many doctors are expected to fail, and there is no real plan that deals with the needs of failing doctors. How can this system succeed in its aim of protecting patients?

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The proposals will, however, meet the pressing political need to "do something." It will bring large financial rewards to the royal colleges.

Most failing doctors are not malevolent but have the simple human weaknesses of physical or mental ill health. The chief medical officer recommended the provision of support services in 1999.[3] The evidence that easy access to support and treatment protects the public has been clear for a quarter of a century, yet still no action has been taken.[4]

The chief medical officer believes 5% of doctors fail over five years. But he is choosing to re-invent medical regulation instead of proposing additional powers for the National Clinical Assessment Service, which is already referred this number of doctors but finds it cannot act effectively. It seems far simpler to give the assessment service the power (behind closed doors) to work to the civil standard of proof and to require appropriate remedial training.

The government, guided by the chief medical officer, could protect patients and support doctors by providing adequate occupational health support, giving the assessment service adequate powers to deal with failing doctors, and allowing the reformed GMC an opportunity to succeed—all of which could be done quickly and at relatively low cost. Its preference for grand schemes over practical actions comes at the expense of both doctors and patients and will in due course be seen for the folly it is.

Bernard Ribeiro, president, Royal College of Surgeons of England, London

I welcome the white paper on medical regulation and am particularly

pleased that the proposal for periodic revalidation is underpinned by a strengthened role for the medical royal colleges. This enhanced role will consolidate our commitment to safety and the highest standards of surgical care for our patients.

The revised proposals relating to the role of regional General Medical Council affiliates are welcome, as is the strengthened role for trust medical directors. Training of these people is critical, and the white paper acknowledges that a high level of investment is needed to establish and maintain effective arrangements.

The introduction of a sliding scale in fitness to practise cases will ensure that a doctor facing erasure from the medical register is judged against an appropriately high level of proof. The GMC has already introduced changes for dealing with fitness to practise cases, and I hope that the independent adjudicating body will recognise the expertise and experience the GMC can add.
We need time to absorb the changes. Successful implementation will require piloting, realistic timeframes, and adequate funding.

James Johnson, chairman of council
British Medical Association, London

I argued in November that the chief medical officer's proposals for reforming and restructuring the General Medical Council represented a major assault on the principle of professionally led regulation. The white paper *Trust, Assurance and Safety* sweeps that principle aside completely and for all health professionals.Government has accepted Janet Smith's argument that being an elected member of a regulatory body, and by implication accountable to a constituency of fellow professionals, is not compatible with acting independently in the public interest. The white paper repeatedly refers to the risk that the standing of a regulator is impaired if the public perceives it to be in hock to the profession it regulates. However, there must be an equally substantial risk that public confidence in the independence of their doctors is undermined if patients believe them to be under state control. Government needs to face up to the reality that 25 years of independent opinion polling by MORI confirms that the public trusts doctors, not politicians, to tell them the truth.

Some progress has been made since the consultation.The GMC's role in governing undergraduate medical education has been secured with a solid, tripartite structure for undergraduate, postgraduate, and continuing education.

The proposals for GMC affiliates have been moderated and the vital responsibility of medical directors for clinical governance recognised. Proposals for relicensure and recertification still need much greater clarity, but the white paper recognises that the majority of doctors retain a lifelong enthusiasm for learning and for developing their practice.

The GMC has already separated the governance of regulation from the delivery of casework, but its good faith in so doing has not been rewarded. Instead, it further loses the right to adjudicate hearings, with its role confined to investigation and prosecution. I am unconvinced that this further separation of functions is necessary or proportionate. It does at least open up a route for the GMC, as the body that sets standards of conduct and competence, to appeal against the findings of disciplinary panels if they fail to uphold those standards appropriately.

However, if the GMC is now the prosecution service for medicine, and if a civil standard of proof is to be deployed, doctors are likely to feel that they are paying not for the privilege of professional regulation but to be policed. I understand and respect the decision of the GMC to embrace the white paper and to work with the grain of emerging public thinking on regulation. But I do have real concerns about how these changes will affect doctors' sense of ownership of their profession and their role in shaping its future.

Professionally led regulation was never a right, nor was it just a privilege. Fundamentally, it was a responsibility on doctors to act in the public interest. Its passing will serve the interests of neither patients nor the profession.

Joyce Robins, codirector
Patient Concern, London

Patients trust and respect the great majority of doctors and appreciate the skilful care they receive. We are tired of headlines exposing the few who let down the profession and shake our confidence. The measures in the government's white paper should ensure that doctors have an opportunity to show their expertise while patients can be assured that any doctor they consult is competent and deserving of their trust.

Self regulation has produced some spectacular failures: Harold Shipman, Bristol, Rodney Ledward, Richard Neale, William Kerr etc. Probably no one believes that another Shipman is lurking, but as Lesley Southgate, past president of the Royal College of General Practitioners, told the Shipman inquiry: "There are doctors out there who are harming patients." It is time for change.

Patients have long believed that the General Medical Council looked after its own. Doctors finance it and therefore they expect its support. Up to now the GMC has acted as investigator, prosecutor, judge, and jury in fitness to practise cases. It is only right that these functions should be split and that an independent organisation will adjudicate.

GMC council members will no longer be elected but appointed, so that they are not chosen on a particular manifesto. The professional majority will go. This will be an improvement only if lay members are genuinely lay. Objectivity is questionable for those who work in the health service.

"In the past, the tendency to give doctors the benefit of the doubt has ended in tragedy."

The most contentious measure is the change in the standard of proof in fitness to practise cases from beyond reasonable (criminal standard) doubt to the balance of probabilities (civil standard). This is about patient safety. The Family Court can take children away from their parents permanently on the civil standard of proof. In both cases the objective is prevention.

In the past, the tendency to give doctors the benefit of the doubt has ended in tragedy. Now it will be possible to act earlier on patients' concerns—well before the point where a string of patients are dead or damaged and a doctor is struck off. The aim is protective, not punitive. No one wants to see doctors struck off. What is needed is intervention—support, supervision, retraining—before conduct can reach this level. The BMA believes that doctors will now begin to practise defensively rather than looking after the interests of their patients. We have more faith in doctors than that.

Most patients marvel that it has taken a string of scandals before the obvious necessity of medical colleges defining the skills and

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standard of performance needed for continuing membership has been recognised. The tightening up of appraisal to include a summative element is essential. The aim must be to gain an objective assurance that a doctor continues to meet the required standards. But we hope we can avoid a bureaucratic exercise with doctors wasting endless time ticking boxes.

If the changes are received in the right spirit by the profession and made to work effectively, then we can all move on, confident that the lessons of the past have been learnt.