

Commentary

The White Paper and regulatory reforms: Beginning the end of professional self-regulation for doctors.

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The White Paper *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*, published by the Government¹ in 2007 proposes several changes in the composition and functioning of the councils that regulate health professionals, including the General Medical Council (GMC). Some of these changes include -

I. ASSURANCE OF INDEPENDENCE IN THE GOVERNANCE AND ACCOUNTABILITY OF THE PROFESSIONAL REGULATORS.

To achieve this, the Paper proposes:

- Parity of membership between lay and professional members for the regulators to be and seen to be independent and impartial, with enhanced accountability to the Parliament.
- Independent appointment of the council members than election to dispel the perception that councils are overly sympathetic to the profession they regulate
- Reducing the size of the councils and making them more-board like to enable them to focus more effectively on strategy and the oversight of their executives.
- Deferring mergers of the professional regulatory bodies, at least until 2011

II. INTRODUCTION OF AN EFFECTIVE SYSTEM OF REVALIDATION

The White Paper also outlines robust revalidatory mechanisms for all statutorily regulated health professionals who will periodically be required to demonstrate their fitness to practise. There are two core components to the proposed revalidation – *relicensure* and *recertification*.

- a) For *relicensure*, all doctors will have a licence to practise to remain on the medical register, to be renewed every five years. This will be based on annual appraisal system which will be modified to have a summative (judgemental) element in addition to the current formative (developmental) structure. A 360° feedback system will also be piloted in England.
- b) *Specialist re-certification* will apply to specialist doctors, including general practitioners requiring them to meet the standards set and assessed by the medical Royal colleges and respective specialist societies.

III. TO ADDRESS CONCERNS AT LOCAL AND NATIONAL LEVELS

It is recognised that the current system for tackling poor performance has a “regulatory gap” whereby a doctor may not inspire confidence of his colleagues or employers, but his or her performance is not so poor that referral to the GMC is indicated. To bridge this gap two changes are proposed at local level –

- Introduction of “GMC affiliates” (mostly senior clinicians) at a regional level in England, and at a national level in Scotland, Wales and Northern Ireland.
- A system of “recorded concerns” against a doctor’s GMC registration

At the national level, as suggested by Dame Janet Smith in the fifth Shipman report², two changes are proposed-

- Use of “civil standard of proof” (on the balance of probabilities), with a sliding scale, instead of currently used “criminal standard of proof” (beyond reasonable doubt) in GMC’s fitness to practise cases for doctors.
- Disassociation of the GMC’s roles of investigation and prosecution from adjudication to ensure complete public and professional confidence.

Both the modifications are accepted by the GMC, are due to be implemented soon and have generated considerable debate and anxiety.

There is little disagreement that the professional self-regulation in place over last 150 years since the inception of the GMC is not adequate to protect our patients. It is also widely recognised that recent enquiring over the last decade including Bristol, Shipman, Ayling, Neale and other similar investigations incriminating the medical profession have significantly eroded public confidence in the medical profession. This has prompted the Government to launch strong regulatory measures to identify and tackle poorly performing doctors at an early stage. While these measures are also meant to have a supporting function in addition to a disciplinary role- with options for rehabilitation and re-training, the Government’s focus is centred primarily on

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the safety of our patients. The White Paper¹ also recognises benefits of a “three-board model” covering undergraduate, postgraduate education and continuing professional development. It is hoped that all the above measures, once implemented and fully operational, will help us restore confidence of the public, profession and politicians in the medical profession. One can therefore foresee overwhelming support among the public, patient-organisations and media for these sweeping reforms in the regulation of health-care professionals, especially doctors. Many might even consider them to be perhaps long overdue.

As majority of doctors provide excellent quality of care, these measures aimed at a relative minority are bound to be perceived to be harsh and heavy-handed on the medical profession in general. For example, the changes in the standard of required proof required in fitness to practise cases from criminal to civil category may result in more erasures from the medical registers, although the GMC denies such a possibility³. The GMC envisages restrictions placed on practice of more number of doctors than increase in suspension rates due to these changes³. There is also a concern that the over-regulated medical environment may generate a culture of fear among doctors. This may, in turn, force them to focus on being politically correct than on concentrating on patient’s well-being, and also to practise defensive medicine—a change already noticeable over last few years. There is no disagreement with Sir Liam Donaldson’s assertion that “in 2006 every patient is entitled to a good doctor” (*Good Doctors, Safer Patients*)⁴, but there is no universally agreed and widely understood definition of what exactly a good doctor is⁵. In the longer term, these changes may reflect in early retirements, disillusioned doctors opting for alternative careers, lack of motivation and depletion of innovation in the medical practice. There would also be little incentive to work hard in clinical practice, as the harder one works and the more patients one treats, more mistakes one is likely to make. In surgical specialties, surgeons may shy away from undertaking complicated and inherently risky cases – surely not a step

in forward direction. Further increasing bureaucracy and paper-work in the appraisal-revalidation process is unlikely to make us better doctors. The proposed modifications in the professional regulation are not convincing enough to ensure that genuine poor-performers are indeed filtered before it is too late. In fact, the crux question that remains unanswered is—whether the proposed radical reforms in the existing system of professional regulation will necessarily identify more poorly performing doctors as envisaged by the Government, or will it merely portray more number of doctors to be poorly-performing?

Like it or loath it, it is clear that these reforms are here to stay. They can be considered as marking the end of self-regulation for medical professionals. If embraced by the profession in the right spirit, and implemented effectively, they will hopefully enable us to strike the right balance between professional independence and regulation, and eventually make it a win-win situation for all NHS stakeholders.

Conflict of interest- None to declare

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