



JOINT CONSULTANTS COMMITTEE

May 2005

CALL FOR IDEAS - CLINICAL PERFORMANCE AND MEDICAL REGULATION: CHIEF MEDICAL OFFICER'S REVIEW FOLLOWING THE SHIPMAN INQUIRY REPORTS

The Joint Consultants Committee brings together not only groups representing consultants (notably the Academy of Medical Royal Colleges and the Consultants and Senior Staff Committee of the BMA) but also a wide range of other organisations that represent the medical profession in the United Kingdom. It meets regularly with officials from the Department of Health and therefore provides a constructive forum for the discussion of issues that affect the delivery of health care and the practice of medicine. The Committee debated the recommendations of the 5th Report of the Shipman Inquiry at its meeting on 11th January 2005, in the presence of Sir Liam Donaldson and of Sir Graeme Catto and subsequently produced a response¹. This document attempts, in the light of that debate, to answer the specific questions posed in Sir Liam's Call for Ideas.

The Committee understands the legitimate public interest in the conduct and competence of doctors and is committed to strengthening the institutions and processes for professional regulation in order to retain the trust of patients and the public. The Committee, and the profession in general, wants to work constructively and coherently towards improving, where necessary, the mechanisms and quality of information required to monitor clinical performance and strengthen medical regulation. It is clearly understood that in order for any appropriate changes to be instituted successfully the profession must collaborate with the public, patients and regulatory bodies.

The Committee is in broad agreement with the principles of professional regulation set out by the General Medical Council in its recent document 'Developing Medical Regulation'² and concurs that a balance must be struck between a system of deterrence (which may restrict professional self-development) and a model of compliance (which may be more difficult to validate). In formulating this response we have attempted to provide answers to the specific questions posed by Sir Liam.

Should doctors' performance be assessed in addition to, or as part of, the annual NHS appraisal? What purpose should appraisal of clinical practitioners have: should it be primarily for governance, with a primarily summative structure and handling; or should it be, as at present, primarily for developmental purposes, with a primarily formative structure and handling? Can it be on both of these bases at the same time? How might small practices and departments be supported in this area? What form should assessment take?

It is our view that the process of appraisal has proven to be a developmental tool of considerable value. Appraisal was conceived as a formative and developmental mechanism, not a mechanism for judging a doctor's ability or conduct in a pass/fail manner, and we would be concerned if this emphasis were to be lost as a result of attempts to modify the process of appraisal during the review of revalidation.

We accept the GMC's view³, however, that components of the same evidence may be used in both appraisal and revalidation and that a summative element has evolved within appraisal over time. We are therefore sympathetic to the suggestion that a more rigorous appraisal system, conducted according to agreed protocols and formally documented, could be used as the basis for local certification leading automatically to revalidation for most doctors.

¹ Joint Consultants Committee. A response to the fifth report of the Shipman inquiry, February 2005

² General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraphs 15-16.

³ General Medical Council. Developing medical regulation: a vision for the future. April 2005, Annex A.

What practical measures would assist with establishing that a doctor continues to be able to provide competent and safe services? Should 360° reporting be introduced by the NHS as part of appraisal? Should there be a confidential reporting system? Should doctors record their experience, learning or educational events in a log-book? Who should be involved in the assessment process?

We are clear that the process of performance assessment, in whatever form it takes, will have to be informed by clinical governance data. However, at present the robustness of such data is open to question and consequently its validity in underpinning appraisal is compromised. There is therefore an urgent need to define the information which will be appropriate and to ensure that it can be captured accurately by the relevant IT systems. The Committee is aware of the groundbreaking work being undertaken in this field by the Dr Foster Unit at Imperial College⁴ but understands that there is still concern about data quality. Whatever mechanism is ultimately agreed, it will be essential that the public as well as the profession is assured that the evidence collected is reliable and appropriate.

The Committee would have no objection in principle to the introduction of a system of questionnaires, such as those being piloted by the GMC,⁵ in order to capture the views of patients and colleagues. Indeed, 360-degree reporting systems are already in use in some systems of postgraduate training. However, the Committee would wish to be reassured that any new measures had been adequately validated prior to their introduction.

It is our view that doctors should have recourse to a confidential reporting system and that such a structure would provide a valuable tool for flagging up areas of concern in respect of doctors' competence. It is important that a new ethos is established in which reporting is not considered to be 'whistle-blowing' but rather an indication of doctors' high regard for the safety of patients and standards of care. Clearly, it will be vital that the system is fair and sensitive to the potential for misguided or unfounded claims.

We believe that it is essential that the assessment process itself must be transparent, objective and profession-led. The process should largely involve doctors from the same field and, when appropriate, suitably trained lay people. We agree with the GMC⁶ that Medical Royal Colleges have a potentially important role in standard setting for this purpose.

How can patients and the public contribute to the maintenance of standards and competence? Should their views about their medical treatment be sought routinely? Or on a sample basis?

Almost all Medical Royal Colleges now involve lay and patient groups in their decision making. It seems appropriate that these groups should be consulted when standards of clinical practice are being formulated. There should also be lay involvement in the quality assurance of the process of revalidation at local level. The General Medical Council already has substantial lay membership to contribute to this process at national level.

How should lessons learnt from patient complaints be fed into the appraisal system? How can staff be encouraged to identify and report poor performance or unacceptable conduct?

We agree that patient complaints (as well as patient audits) should be used to inform the appraisal process. Clearly, a willingness to learn from mistakes is an essential aspect of reflective professional practice.

As noted above, recourse to an effective confidential reporting system would undoubtedly encourage staff to identify and report poor performance or unacceptable conduct. More importantly the development of a 'no-blame culture' within the NHS would propagate an environment in which concerns about the delivery of care could be openly identified and constructively addressed. It is important to recognise the work being carried out by the National Patient Safety Agency in this area⁷. Their electronic reporting system is, of course, national and anonymous but a similar system of data capture could be devised for local use.

⁴ <http://www.drfooster.co.uk/hp/index2.asp>

⁵ General Medical Council. Developing medical regulation: a vision for the future. April 2005, Annex A.

⁶ General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraphs 121-127.

⁷ <https://www.npsa.nhs.uk/staffform/>

What should be the core purpose(s) of revalidation? Are the GMC correct when they say that the purposes are to contribute to raising standards by requiring doctors to demonstrate that they have reflected on their practice; and to protect patients by securing confirmation that doctors are up to date and fit to practise, by providing a backstop where local systems do not exist, or exist but are inadequate; and through robust quality assurance mechanisms?

We agree with this view of the core purposes of revalidation.

An answer to this will be needed because it will influence data requirements, how 'success' and 'failure' are handled and how the process is presented to the public and to the profession. Should the emphasis be on securing public trust, on promoting CPD and the raising of standards, on detecting impairment, or on a combination of these aims?

A combination of the stated aims will be necessary. It is essential that the public trust is secured and promoting CPD, raising standards and detecting impairment will each play an important role in achieving this goal. Moreover, pursuit of these aims will act to ensure that the profession retains appropriate skills, abilities and attitudes towards patients. However, it is essential that any process takes into account the complex environments in which doctors work. Data employed to assess quality, standards and competence should be sensitive to the organisational context from which it is drawn. Such information must be factored into any assessment of an individual's performance.

In the light of this, what should the broad structure of revalidation be? Should it be a screening ('assessment level 1') process aimed at identifying practitioners at risk of having a fitness to practise problem; or aimed at actually identifying dysfunctional practitioners (case finding, or 'assessment level 2'); or, as the legislation currently provides, aimed at evaluating fitness to practise (diagnostic or 'assessment level 3')?

The Committee is in general agreement with the vision for revalidation set out by the General Medical Council⁸. This has the advantage of making use of local appraisal systems for screening purposes and will not therefore involve the development of a potentially cumbersome and time-consuming centralised process at national level. Such a process will, of course, need to be developed for those doctors who are thought to have deficiencies, however identified. If considerable reliance is to be placed upon local appraisal for the purposes of revalidation, there will need to be a robust system of quality assurance in order to reassure the public and the critics of professional self-regulation that standards are being maintained. Lay involvement will be helpful here, as will the demonstration by the institution in which the doctor works that core standards are being maintained (for example by means of the Annual Health Check carried out by the Healthcare Commission⁹).

What attributes (knowledge and skills), behaviours and attitudes should doctors have to demonstrate to maintain their registration? Are there any other relevant attributes which should be assessed?

How should the required standards be set? Should there be objective criteria? How should these be identified and measured?

Should there be a core evidence set for revalidation? How should it be defined?

It is important to recognise that doctors' practice varies substantially from specialty to specialty and, in many instances, within individual specialties. It is not practicable to lay down a detailed list of knowledge and skills which would be appropriate for all doctors. The generic principles laid down in *Good Medical Practice*¹⁰ are widely accepted as encapsulating the attributes which all doctors should be able to demonstrate in their relationships with patients and colleagues. If more specific information is required, then the Committee considers that the advice of the relevant Medical Royal College or professional association should be sought.

Nevertheless, we strongly endorse the opinion of the General Medical Council that 'revalidation should be based on performance, not simply competence'¹¹.

⁸ General Medical Council. Developing medical regulation: a vision for the future. April 2005, Annex A.

⁹ http://www.healthcarecommission.org.uk/ContactUs/RespondToAConsultation/CurrentConsultations/fs/en?CONTENT_ID=4016872&chk=61P6R5

¹⁰ General Medical Council. Good Medical practice. Third edition. May 2001.

¹¹ General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraph 119.

How should 'failure to revalidate' be handled, in the light of topics I and II above? How can we avoid 'double jeopardy', with repeated assessments?

When a doctor's fitness to practise has been called into question what arrangements should there be to protect the public? How should the GMC monitor the compliance of conditions it has imposed on a doctor? Are there any extra safeguards for a doctor being retrained above those required for a doctor in training?

The first priority in such cases must be patient safety. In cases where a doctor is deemed to present an immediate danger to patients it should be expected that the doctor is suspended with immediate effect pending further investigation. When other factors, including local appraisal, suggest that a doctor cannot automatically be recommended for revalidation, there will be need for central assessment by the General Medical Council. It would be unfortunate if the GMC's decisions were to be frequently challenged by the Council for Healthcare Regulatory Excellence, although the Committee recognises the importance of the opportunity that this body provides to reassure the public that the GMC's decisions are subject to external scrutiny. There is clearly a need at present to streamline the work of the various regulatory bodies¹² and we welcome the announcement that a review of the regulation of other groups of healthcare professionals will be undertaken at the same time as the CMO's review¹³.

Supervision of a doctor's work when restrictions on practice or retraining are required by the GMC can only realistically be undertaken locally. We agree that this work should be coordinated by the GMC, involving where appropriate the National Patient Advisory Service, and note with approval the establishment of the GMC's Case Review Section and Health Review Group¹⁴.

What arrangements are needed for doctors whose fitness to practise fails to meet the necessary standard? Is retraining a realistic option for all doctors? Who should pay for this? What arrangements should be for doctors to move to other duties and to provide exit strategies?

We agree with the GMC's view that retraining is unlikely to be appropriate for doctors with serious attitudinal problems or with health impairment¹⁵. Once again, local arrangements need to be coordinated to the satisfaction of the GMC and a programme with clearly defined competencies and mechanisms for assessment must be agreed. There will be circumstances under which it will be to the advantage of the local employers to pay for retraining, especially since it is likely that there will be an element of service provision in any such programme. However the Committee accepts that there will be occasions when the doctor being retrained could be expected to pay at least part of the costs.

What else is needed to provide patients and the public with the assurance they need to maintain confidence in the competence and safety of medical practice?

It is widely acknowledged that errors in clinical practice usually involve an element of system failure, even if a doctor's fitness to practise is impaired. Frequent and robust scrutiny of clinical standards in all institutions providing health care will provide an important safeguard for patients and the public. We therefore welcome the Healthcare Commission's important initiatives in this area¹⁶.

How should information on practitioners' fitness to practise be held and made available, including information from appraisal, revalidation and fitness to practise (including local disciplinary procedures)? Should this be a single national database or a collation of local NHS and other databases (eg the GMC register)?

It is our view that the principle of transparency is vital in relation to maintaining standards of practice, as well as to the disclosure of information. This principle should therefore extend to the existence of restrictions on a doctor's practice. We wish to see the development of a policy of tiered disclosure to apply to all persons seeking information about a doctor. We therefore welcome the GMC's proposals to improve the accessibility of their unique database containing information about every doctor registered in the UK¹⁷.

¹² General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraph 24.

¹³ Government press release 17/03/05.

¹⁴ General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraphs 143-147.

¹⁵ General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraphs 149-150.

¹⁶

http://www.healthcarecommission.org.uk/ContactUs/RespondToAConsultation/CurrentConsultations/fs/en?CONTENT_ID=4016872&chk=61P6R5

¹⁷ General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraphs 50-54.

Should the GMC continue to be a complaints-handling body which receives complaints directly from any source, or should it be a body to which complaints are normally only referred by healthcare organisations and other public bodies where they have passed a threshold indicating that the doctor may be unfit to practise?

It is the Committee's view that typically complaints should be dealt with locally, in the first instance. We support the concept that the GMC should only become involved in handling complaints when certain well-defined criteria have been met.

Will the complaints portal recommended by Dame Janet, together with appropriate public information about the differing aims of complaints procedures and fitness to practise procedures, resolve current public uncertainty about how and where to make a complaint; or is better role-definition for the various organisations involved, expressed where necessary in legislation, essential?

We support the development of the proposed complaints portal and would be pleased to participate in discussions about how this could best be achieved.

What should the regulation of the medical profession look like?

The regulation of the medical profession must be conducted at a national level with a UK-wide regulatory process overseen by a single body. There must be active involvement of patients and the public but they will rely heavily upon specialised medical advice. The regulatory body must be clearly accountable to the public and its decisions should be subject to independent scrutiny.

What should be the role and structure of the General Medical Council in the future? What should the primary purpose of the Council (which is currently composed of 35 members) be – governance and policy development, i.e. more like a publicly accountable Board – or delivery, ie directly involved in exercising the GMC's powers and functions? In either of these settings, what should its size be and how should members be appointed? If its function is governance and policy development, who should carry out the work of the Council on delivery? If its function is delivery, how should these powers be delivered? In fitness to practise, the following key components - setting standards of conduct, policy and procedural rules; investigation of complaints; case presentation; adjudication - are currently delivered by the GMC. How should these elements be organised in the future?

Recent reforms of the GMC have established a small governing body with overarching responsibility for governance and policy. We believe that this reorganisation has been largely successful and would not wish to see a change of emphasis at this time. We do, however, support the suggestion that the constitution of the body should be reconsidered, to permit the replacement of some medical members by additional doctors appointed by the Privy Council, while maintaining the current overall numbers of lay and medical members.

The GMC currently has an elaborate system for the delivery of its functions. In particular, there exists a trained workforce of medical and lay panellists¹⁸ who appear to have a successful track record in adjudication¹⁹. If, as Dame Janet Smith has suggested, adjudication were to be undertaken by a body independent of the GMC, it would be necessary to recreate this expertise. It would be particularly important, in the view of the Committee, to ensure that appropriate medical input was available to adjudication panels, if the process were to retain credibility within the profession. The mechanism by which suitable individuals were selected for this work would require careful consideration. The Committee is not convinced that a sufficiently detailed case has been made for change to the current system.

Do we have the right balance between regulation and freedom to practise (including innovation)?

It has been our clear view throughout this response that mechanisms for assessing clinical performance and the process of medical regulation must be perceived as fair and reliable by both the profession and the public. From the perspective of the profession changes must not exacerbate the workload pressures which currently exist by placing unnecessary burdens on doctors. Neither must reform be perceived as disproportionate nor regulation as overly restrictive as this will undoubtedly have a detrimental effect on the recruitment and, in particular, retention of doctors at a time when a growing and stable workforce is required.

¹⁸ General Medical Council. Developing medical regulation: a vision for the future. April 2005, Annex E.

¹⁹ General Medical Council. Developing medical regulation: a vision for the future. April 2005, paragraph 174.

We are concerned that the Fifth Report of the Shipman Inquiry and the current review of medical regulation could lead to a situation in which the profession is overly regulated with too great an emphasis on individual shortcomings and too little upon failures in the systems in which they operate.

What alternative models are there in other fields of endeavour in the UK or elsewhere? How could these be adapted for the medical profession in the UK?

We have no information on this point but believe that the GMC has begun a process of reform which will place it at the forefront of professionally led regulation.

Should the regulation system be made more accountable and intelligible to the public? What should be the relationship between the GMC and Council for Healthcare Regulatory Excellence (CHRE)? How should the effectiveness of that relationship be evaluated? Should the GMC be made directly accountable to Parliament, as Dame Janet has recommended?

We agree that the regulation system should be made more accountable and intelligible to the public. We also agree with the Fifth Report's recommendation that the GMC should be directly accountable to Parliament. Similarly, the proposal that an annual report be published by the GMC for submission to a Parliamentary Select Committee is also valuable and would likely foster greater confidence in its function.

The Committee has some concerns about Dame Janet's recommendation that Section 29 of the Act should be amended so as to clarify that the Act provides for the CHRE to appeal against 'acquittals' and findings of 'no impairment of fitness to practise', as well as in respect of sanctions which it believes were unduly lenient. Whilst we are supportive of steps to aid clarification, we would urge that these recommendations are dealt with cautiously as the CHRE's relationship with the GMC is still in the process of development. We hope that there will ultimately develop a streamlined and transparent process which will have the confidence of both the public and the profession.