

Adam Smith Institute

Patient Centred Medical Regulation

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Drivers for Change

There are several forces driving change to medical regulation. Self regulation works for professions trusted by the public. The British public do not trust the medical profession for a variety of reasons:

1. A better educated public. The public have access to information through the Internet and the media and are increasingly asking doctors more pointed questions. Public expectations are high. Doctors have not come to terms with the IT revolution and the shift in the balance of power between doctors and patients.
2. Conflicting objectives. Medical regulators are having to reform the regulation of doctors – but the ‘regulators’ protect the doctors as well as the patients. It is in charge of the number of doctors and is extracting ‘monopoly rent’.
3. The inadequacy of the General Medical Council. The GMC has behaved in an appalling way over the past twenty years. There is no need to ‘throw the baby out with the bathwater’ – self-regulation is a good idea if done properly – the GMC have not managed self-regulation effectively. The GMC have a credibility problem with patients.
4. Media focus. Perceptions are all important. Media headlines create perceptions of a problem. In reality there are very few bad, criminal, misguided or incompetent doctors, but those that are receive high media profile.
5. Complexity of the complaints system. There is a multifarious network of relationships which also cause perceptions problems. The situation is getting worse, given the establishment of NICE and the Commission for Health Improvement and devolution meaning separate bodies in Scotland. There is no single point of contact.
6. Issues of accountability. It is unclear which organisation is accountable for poor performing professionals, education, knowledge control etc.
7. The behaviour of doctors. The medical profession is trades-union dominant and subject to a provider-producer relationship. The medical professional has been happy to see bad practice continue. There has been enormous variance in service standards and there has been a collective inertia and silence in the profession.
8. Communication. Doctors claim they have been forced to compromise on medical standards, most importantly the time they have for communicating with patients. Most complaints arise from the lack of time for communication. Paper reports are valuable, but patients need the information interpreted by experts.

9. Dysfunctional management. There is arrogance amongst consultants and General Practitioners are stubborn. They are independent and have tremendous responsibility. Many doctors have a paternalistic approach to patients. The current system is based on deference. The profession should admit its arrogance and move from its aggressive / defensive stance to a more honest relationship with patients.

What and How to Regulate?

Doctors must be regulated by doctors because they are the only ones with the professional expertise to do so. The reality is that doctors have never been self-regulated. There has always been a mix of self- and external regulation.

Five per cent of doctors are estimated to be making the wrong decisions – that amounts to 5,000 doctors with 100,000 patients. Many are not known about, apart from anecdotal evidence in the profession. There are very few customer complaints about doctors in reality – but there is widespread deficient practice which is in need of systemic review.

The risk of regulation is an increase in defensive medicine. The complaints process needs to disentangle the exact nature of complaints from patients. Complaints often refer to how patients perceive themselves to have been treated by their GP – the technical and the personal are often blurred.

The motivation of doctors needs more analysis. Standards are implicit in medicine – they need to be explicit – new value-led standards. Both individual and collective accountability needs significant analysis. The risk of error needs to be factored in to a subjective discipline where judgements are based on imperfect information.

The Cabinet Office's 'Better Regulation Taskforce' led by Lord Haskins has examined GPs and the issue of self-regulation. It has five principles against which it judges regulations – transparency, accountability, targeting, consistency and proportionality. An effective system of regulation passes all five tests. The alternative to self-regulation is State regulation – the complexities are obvious.

The NHS does not measure outcomes. No surgical procedure has comparable outcome measurements. BUPA has measured outcomes of one-day patient stays and has data on 25,000 patients to date. Even small amounts of data are useful in measuring outcomes.

Self-analysis of the industry is key. There will be more intrusive demands for information from doctors – the data will then be made public. That will allow an independent body to take an even-handed look at the profession and judge the public-interest. The 'public-interest' is not always the same as 'patient-centred' health care.

Regulation can be divided into three roles – judiciary, policing and education. Good doctors will volunteer for audit. The NHS needs to worry about those doctors who will need to be dragged kicking and screaming to be audited. In the US medical practitioners pass a peer-review exam every year in order to qualify for Federal funds. Doctors need to find the time in their busy

schedules to keep training and learning – a high-volume low-quality service is no longer acceptable.

A Model for Reform

- The test for regulation must be ‘Does it add value to the public-interest?’.
- The national management of the NHS has to create an environment which is patient-centred.
- Regulators need to be publicly accountable. The GMC should move from professional-focused to a patient-focused organisation.
- The framework of ‘Good Professional Regulation’ used by lawyers is a possible model for the medical profession.
- A mechanism is needed to identify problems before complaints arise. The current system is not geared to spotting and stopping poorly performing doctors early. Liam Donaldson’s initiative is welcome – an early spotting and reporting structure to learn from near misses.
- There needs to be lay and expert input into regulation. Expert input is better at the regulatory stage. Experts need to regulate experts. Some areas of medical practice are so specialist that very few people can judge clinical competence. These experts need to be supported by those who can take a detached and impartial view of what doctors are doing.
 - Who chairs the regulatory and disciplinary proceedings is important – it is possible that a judge would be better placed to weigh evidence, advised by professionals.
- The complains process should be simplified and more open – with one point of contact. Complaints that are dealt with properly dwindle away and are not taken further. The complaints procedure needs to be transparent and efficient. Patients need to know to which body they should go to complain.
- National regulators need to set an framework – but an effective local complaints system is the key to successful regulation. Though there is more scope for a unification of a complaints and regulatory system, one super-regulator will not work.
- The first step should be the complaints procedure, similar to the IHA complaints mechanism which includes clinicians. The GMC is the last body the patient should be concerned about.
- Openness and transparency are important. Public disquiet based on lack of trust and transparency will be diminished if more data are published. Patients need to know more about a doctor’s experience and background. They only hear rumours. There should be external peer review and patient review of clinical practice.

- Communication skills are a key professional skill. The rise in technological medicine and the increased ability to help patients mean that communications is not seen to be as valuable a skill as it was eighty years ago. Two fifths of doctors do not believe that good communication skills are important enough for remedial action to be taken if they skills are poor. Doctors need to be more discursive with patients.
- Good information. There needs to be an increased focus on outcomes, and the implementation of procedures to define outcomes. This would allow easy comparisons and analysis to spot departures from the norm.
- There needs to be greater investment in doctors over the longer-term. Consultants need training and re-skilling throughout their professional lives.