

The Changing Medical Regulatory Context: Focusing on Doctor's Educational Practices

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ABSTRACT

This paper outlines contemporary developments in the regulation of the medical profession in the United Kingdom. It discusses how recent reforms in medical regulation illustrate that the state has responded to calls to reform medical governance so it is more open, transparent and publicly accountable by subjecting rank and file doctors and their elite governing institutions to a rationalistic-bureaucratic discourse of standard setting and performance appraisal. It argues for the need for social scientists to assess the impact of this development by conducting research into how doctors keep themselves up to date and 'fit to practice' in their chosen medical specialty.

Key words

Governmentality, medical profession, medical regulation, revalidation

Introduction

With two hundred and fifteen known victims the general practitioner from Hyde in Manchester, Dr Harold Shipman, was one of the most prolific serial killers the United Kingdom has produced. Without a doubt the Shipman case possesses a great deal of notoriety precisely because he was a doctor and so a member of a profession which has publicly avowed to use its not inconsiderable expertise to do what it can to preserve life and promote public health (Gladstone, 2000).

In her subsequent independent public review of the Shipman case Dame Janet Smith (2005) was highly critical of current institutional arrangements designed to ensure doctors remain 'fit to practice' in their chosen specialty, as well as what she considered to be an elitist and 'closed shop' mentality concerning the regulation of doctors. Her report made it clear that something needed to be done to change the organisation and culture surrounding medical governance in the United Kingdom. This paper documents governmental reforms which have been introduced in light of the Shipman case to ensure that the general public is protected from underperforming and errant doctors. In doing so it highlights a currently under-researched area for empirical inquiry on behalf of social scientists.

Regulating medicine: the impact of the political re-emergence of liberalism

Before outlining current developments in the regulation of doctors it would be useful to begin by tracing the historical development of medical governance in the United Kingdom. Until relatively recently the medical profession in the United Kingdom was regulated by a single institution - the General Medical Council (GMC). The GMC was established by the 1858 Medical Act. Historically it has been dominated by a mixture of elected 'in house' members of the medical profession (Gray and Harrison, 2004). It is only in the last three decades that non-medical GMC 'lay members' have begun to make their presence felt, and even then they have remained in the minority (Elston, 2004).

The GMC's responsibilities are essentially twofold: to maintain a register of qualified medical practitioners and to define the nature of the qualifications necessary to obtain registration. The 1858 Medical Act is often held to be a landmark in the governance of medical training and regulation in the United Kingdom as its enactment entered medicine into a regulatory agreement with the state (Stacey, 1992). Medicine and its practitioners gained the privilege of professional

self-regulation in return for promising the public they could trust the competence of registered medical practitioners (Allsop and Saks, 2002).

Through its control of the GMC for 150 years the medical profession possessed an occupational monopoly over its members' training, discipline and practice. Other professions such as law have similar monopolistic control over entry into and exit from state registers of qualified practitioners (Gladstone, 2000). But the governance of professional forms of expertise has gradually changed over the last three decades (Freidson, 2001). The 1970s saw the renewal of liberalism as an economic and political ideology, with its emphasis on enterprise and individualism, advocacy of 'rolling back the state', and belief in the ability of the discipline of the market to promote consumer choice, improve service quality and minimise risk (Clarke, 2004). The neo-liberalism of Margaret Thatcher's conservative government of 1979 possessed an ideological allegiance to the 'invisible hand' of eighteenth century 'free market' classical liberalism, which in turn led it to possess an overriding concern for the '3 Es' - economy, efficiency and effectiveness (Rhodes, 1994).

Nikolas Rose (1996) argues that during the nineteenth and twentieth centuries the increasingly rational, experimental and scientific basis of modern forms of expertise led to them becoming integral to the exercise of political authority. So much so that experts such as doctors gained:

...the capacity to generate 'enclosures', relatively bounded locales or fields of judgement within which their authority [was] concentrated, intensified and rendered difficult to countermand (Rose, 1996: 50).

However, as a result of the re-emergence of liberalism, these enclosures have been 'penetrated by a range of new techniques for exercising critical scrutiny over authority – budget disciplines, accountancy and audit being the three most salient' (ibid.: 54).

Rose (1996, 1999) emphasises the enormous impact of the trend in all spheres of contemporary social life towards audit in all its guises, but particularly for judging the activities of experts. The promotion of the enterprise culture of neo-liberalism involves the creation of processes where subjects and their activities are 'reconceptualised along economic lines' (Rose, 1999: 141). Similarly, Gordon (1991: 43) argues that entrepreneurial forms of governance rely on contractualisation as they seek 'the progressive enlargement of the territory of economic theory by a series of redefinitions of its object'. That is, entrepreneurial forms of governance 're-imagine' the social sphere as a form of economic activity by contractually: reducing individual and institutional relationships, functions and activities to distinct units; assigning clear standards and lines of accountability for the efficient performance of these units; demanding individual actors assume active responsibility for meeting performance goals, primarily by using tools such as audit, performance appraisal and performance-related pay (du Guy, 1996).

Under liberal 'mentalities of rule' judgements and calculations are increasingly undertaken in economic cost-benefit terms, and in doing so give rise to what Lyotard (1984: 46) terms 'the performativity principle', whereby the performances of individual subjects and organisations serve as measures of productivity or output, or displays of 'quality' and the ability to successfully minimise risk, so 'an equation between wealth, efficacy and truth is thus established' (Lyotard 1984: 46). For example, Osborne (1993) discusses how, since the re-emergence of liberalism, there has been a gradual reformulation of health care policy and practice, so that 'the field of medicine' is more than ever before simultaneously both governed and self-governing. A key part of this process is the subjection of the activities of medical practitioners to an additional layer of management and new formal 'calculative regimes' (Rose and Miller, 1992), such as performance indicators, competency frameworks and indicative budget targets (Rose, 1993). Certainly, in spite of being highly critical of their conservative predecessors, New Labour has introduced a raft of reforms which have placed doctors under greater surveillance than ever before and in doing so

have challenged traditional clinical freedoms (Slater, 2007). Under the guise of treating 'patients as equal partners in the decision-making process' (Department of Health, 2000: 2) New Labour has introduced a comprehensive, management-led system of clinical governance into the NHS, designed to set and monitor standards governing health care delivery (Department of Health, 1998).

Brian Slater (2001) believes that New Labour have utilised a:

...rationalistic bureaucratic discourse of regulation which reveals itself through increasingly extensive rule systems, the scientific measurement of objective standards, and the minimisation of the scope of human error. Behind it lies a faith in the efficacy of surveillance as a directive force in human affairs. (874)

This new rationalistic-bureaucratic discourse, with its focus on the surveillance and economic management of risk through standard setting, transparent performance monitoring and appraisal, has presented a significant challenge to the principle of clinical freedom 'at the bedside' (Waring, 2007). As Stephen Harrison has argued, there seems to be a feeling of disquiet within the medical profession with what is ultimately seen to be a politically motivated and unrealistic tendency on the part of government to seek to economise and minimise clinical risk by turning medical work into a series of routine 'step by step' rules and procedures against which a clinicians' performance can be measured (Harrison, 2004). For many doctors this approach fails to recognise the importance of the tacit and personal dimensions of medical expertise and the inherent risks present in messy 'real world' clinical practice situations (Bruce, 2007). Certainly, many would argue that these situations are decidedly different from the sanitised world assumed by clinical guidelines and protocols (Black, 2002).

Yet even the most ardent supporter of a doctor's rights to clinical freedom has to acknowledge that a seemingly ever growing number of high profile medical malpractice cases have served to further legitimatise arguments for the need for state intervention to reform medical regulation (Allsop, 2006). History shows that medical elites such as the British Medical Association have until relatively recently refused to acknowledge the need to change. Additionally the medically dominated GMC has been representing doctors, not regulating them (Stacey, 2000). Consequently the GMC is perceived by many to be failing as a regulatory body in its statutory duty to protect the general public (Gladstone, 2000). For example, in the final report of her review of the Shipman case Smith (2005) echoed the opinion of many an impartial observer when she argued that although the GMC had changed in recent times it had not changed enough:

I would like to believe that the GMC's working culture would continue to change in the right direction by virtue of its own momentum. However, I do not feel confident it will do so. I am sure there are many people within the GMC, both members and staff, who want to see the regulation of the medical profession based upon the principles of 'patient centred' medicine and public protection. The problem seems to be that, when specific issues arise, opposing views are taken, and as in the past, the balance sometimes tips in the interests of doctors. (1176)

Medicine's 'new professionalism' and current reforms to medical governance

It can be argued that the last three decades have seen the emergence of a cultural shift away from emphasising 'professional autonomy' and towards 'professional accountability' (Davies, 2004). A mixture of neo-liberal market imperatives and growing calls for state intervention to minimise public exposure to clinical risk, have together led successive conservative and New Labour governments to act to 'open up' the previously 'closed shop' field of professional regulation (Kuhlmann, 2006). More than ever before there is inter-professional co-operation and managerial and lay involvement in the regulation of professional expertise within the health and social care

arena (Davies, 2004). The changing political climate surrounding the regulation of professional forms of expertise has in turn required doctors to accept the need to adopt more open, transparent and inclusive governing regimes, which furthermore rely upon a risk-focused best-evidenced approach to medical governance (Searle, 2000; Catto, 2006).

To ensure their own 'fitness for purpose' the GMC must possess clear standards that can be operationalised into performance outcomes against which the 'fitness to practice' of members of the profession can be regularly checked (Irvine, 2003). This has led to the emergence of a 'new medical professionalism', sometimes called 'professionally-led' regulation, as doctors have sought to adapt to changing circumstance whilst simultaneously seeking to maintain the principle of self-regulation, albeit in a new, more publicly accountable form (Irvine, 2006). As the ex-chairman of the GMC Sir Donald Irvine (2001: 1808) notes, 'the essence of the new professionalism is clear professional standards'. Consequently the GMC's disciplinary procedures have been overhauled and independent investigation has revealed that

...there has been a distinct shift in disciplinary proceedings towards protecting patients and a 'repudiation' of...closed ranks, self-interested regulation. Fraud, dishonesty or the abuse of a privileged position is also treated harshly (Allsop, 2006: 631).

Simultaneously the GMC has enforced a move towards a competence-focused, outcome-based approach to medical training and career progression by means of formal appraisal (Black, 2002). Such moves signal the beginning of proactive surveillance, inspection and control of the programme of delivery of medical training at undergraduate, postgraduate and continuing levels (Stacey, 2000).

The advocacy of a 'new professionalism' is undoubtedly an attempt to establish a new contractual relationship between the medical profession and the general public against the background of increasing government intervention into the field of medical regulation (Slater, 2007). But such developments should not be regarded with cynicism by critical observers. It is not simply a straightforward situation where medical elites are seeking to maintain collective self-regulatory privileges at all costs. Contemporary challenges to self-regulatory privileges have brought to the foreground the fact that the principle of medical self-regulation was first institutionalised in the form of the GMC as it provided a workable solution to the complex problem of 'how to [both] nurture and control occupations with complex, esoteric knowledge and skill...which provide us with critical personal services' (Freidson, 2001: 22). Given the specialist nature of medical expertise it can be argued that the principle of professional self-regulation is justifiable; it is particular instances where individuals have abused their position that are not. Professionals must now admit to previous errors and misdemeanours and work with patient representative groups and other health and social care professionals to make sure such abuses do not happen again (Irvine, 2006).

Furthermore, reforms which have been introduced as a result of high profile malpractice cases such as the Bristol Royal Infirmary scandal¹ have reinforced the fact that effective medical regulation, like the effective delivery of health care, requires the co-operation and proactive

¹ The Royal Bristol Infirmary case came to light in 1998, after 29 babies had died during a cardiac operation, a mortality rate far higher than expected. Three individuals were involved in the case, accused of unprofessional practice - Mr James Wisheart, Dr John Roylance and Dr Janardan Dhasmana. Following a public inquiry Wisheart and Roylance were banned by the GMC, while Dhasmana was suspended. The resulting Kennedy Report led to the establishment of Clinical Governance frameworks within the NHS. The GMC president at the time - Sir Donald Irvine - provides an insightful account of the effect of the Bristol case on medical regulation in his book *The Doctors' Tale: Professionalism and Public Trust*.

involvement of medicine's elite institutions (Gray and Harrison, 2004). Yet the reality is that cases such as Bristol and Shipman have reinforced that doctors can no longer be left alone to manage their own affairs (Stacey, 2000). For example, during his trial it was uncovered that Shipman had previously been before the GMC's disciplinary committee in 1976 for dishonestly obtaining drugs and forging NHS prescriptions. He had been dealt with leniently and essentially 'let off' with a warning. However, if he had been dealt with differently at the time he would not have been free to work unsupervised and kill so many of his patients, a reflection that led Smith (2005: 1174) to end her review of the Shipman case by stating she was 'driven to the conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors lingers on'.

In her report Smith (2005) discussed how the elected nature of medical members on the GMC made the central issue of protecting the interests of the public difficult for members. She noted that

...it seems....that one of the fundamental problems facing the GMC is the perception, shared by many doctors, that it is supposed to be 'representing' them. It is not, it is regulating them....In fact the medical profession has a very effective representative body in the BMA, it does not need – and should not have – two (1176).

Her recommendation was that the makeup of the GMC be changed so that elected members were replaced with nominated members. These were to be selected after a period of 'open competition' on the basis of a candidate's ability to serve the public interest. Smith also highlighted key lessons which needed to be taken on board by NHS management and the medical profession in relation to topics such as the checking of death certificates, scrutiny of single-handed GP practices and the monitoring of death rates and medical records within Primary Care Trusts. There can be no doubt that the Shipman case highlighted the fact that medicine's 'new professionalism' was not in itself enough to protect the general public. It was clear that measures needed to be introduced to ensure that each and every doctor in the United Kingdom is 'fit to practice' and medicine's regulatory institutions are similarly 'fit for purpose'. As the then Secretary of State Alan Milburn made it clear at the time,

...the GMC...must be truly accountable and it must be guided at all times by the welfare and safety of patients. We owe it to the relatives of Shipman's victims to prevent a repetition of what happened in Hyde (quoted in Gladstone 2000: 10).

In 2007 the Health and Social Care White Paper was announced (The Secretary of State for Health, 2007). The Health and Social Care Act came into being in 2008. This contained two key reforms in relation to the regulation of the medical profession. First, the GMC will undergo an overhaul, its current membership reduced from thirty-five to twelve, all of whom will be elected independently. Six of these twelve members will be non-medical lay members. For the first time there is the possibility of a non-medical GMC president, although it is open to debate if, in practice, the wider medical profession will accept a non-medical GMC president (Catto, 2006). Furthermore, the GMC is to lose its power to adjudicate on fitness-to-practice cases, which will now be considered by an independent body. Such cases will now be judged on a civil standard of proof - on the balance of probability. At present, they are based on the criminal standard - beyond all reasonable doubt, a situation that has frequently led sociologists to argue that the GMC's disciplinary procedures have first and foremost protected underperforming doctors instead of members of the general public (Stacey, 1992, Allsop, 2006). The GMC is then left to concentrate on investigating complaints against doctors, but will not be responsible for deciding on relevant sanctions. Additionally, what is to be known as a 'GMC affiliate' will be embedded within local NHS accountability structures. This affiliate's remit includes co-ordinating the investigation of

complaints at a local NHS trust level.

This leads to the second key part of the current reform agenda, namely that the affiliate will work with medical educators concerning the arrangements for ensuring that every doctor is 'fit to practice' in their chosen specialty. Known as revalidation, this process consists of two elements - relicensing and specialist recertification (Donaldson, 2006). Relicensing embeds medical regulation within the government's clinical governance agenda. Doctors currently have to undergo an annual check of their performance, known as annual appraisal, as part of their NHS employment contract (Black, 2002). Smith (2005: 1048) strongly felt that the current appraisal system would not have identified Shipman and does 'not offer the public protection from underperforming doctors'. Under the new proposals appraisal will still occur annually, however it will be significantly strengthened, with greater direct testing of a doctor's competence in regards to the completion of key day-to-day work tasks. All doctors will now have to pass the relicensing requirement that they have successfully completed five annual appraisals in order to stay on the medical register (The Secretary of State for Health, 2007). Specialist recertification is new and, like recertification, will occur every five years. It will involve a thorough 'hands on' assessment of a doctor's 'fitness to practice' in their chosen medical specialty (Donaldson, 2008). It is expected that a mixture of clinical audit, direct observation, simulated tests, knowledge tests, patient feedback and continuing professional development activities, will together ensure specialist recertification. Both the relicensing and specialist recertification elements of the revalidation process are now being piloted, with a view to their being formally introducing nationally from late 2010 onwards.

Highlighting new research avenues

The developments outlined in this paper make it clear that we now are witnessing the beginning of a significant and far reaching period of change in the regulation of medical expertise whose full effects will, in all likelihood, not be known for at least another generation. This provides an opportune moment for social scientists to reflect on existing sociological literature concerning medical autonomy in order to establish areas for empirical research and theoretical development.

The sociological study of medical autonomy has conceptualised recent developments in medical governance and practice under the banner of the respective proletarianisation, deprofessionalisation and restratification theses (Elston, 2004). The deprofessionalisation thesis focuses on topics that indicate that there has been a decline in the public's trust of medicine and on the threat this poses to the principle of professional self-regulation (Elston, 1991). The growth of media coverage of gross medical malpractice cases such as Shipman is a good example. The deprofessionalisation thesis focuses upon the fact that attitudes to traditional forms of authority are changing and highlights that the public increasingly expects their governing institutions to operate in a transparent and accountable manner. In contrast, the proletarianisation thesis highlights the existence of the potential for expert work in general, and medical work in particular, to become subject to rationalisation and routinisation. It focuses upon how this causes medical work to become subject to managerial bureaucratic control in the name of controlling costs, minimising risk and promoting consumer choice (Elston, 2004). Finally, the restratification thesis acknowledges that changes have occurred in medicine's relationship with the general public, and that this is probably due to medical knowledge and expertise expanding and becoming formalised into 'step by step' rules and procedures, particularly with the advent of computer technology and the information and communication revolutions. However, instead of charting the possible negative consequences of this situation in terms of doctors' individual and collective perceptions of their diminishing clinical freedoms 'at the front line', the restratification thesis focuses upon how the medical profession is becoming 'restratified' into more pronounced 'elite' and 'rank and file' roles (Freidson, 2001). Here it seeks to chart the consequences of the rise of a medical administrative elite, grouped around 'the academy' and royal colleges, and

charged with standardising the everyday clinical decisions of rank and file doctors (Kitchener, 2000). This elite uses devices such as evidence-based medicine and 'formalised tools such as audits, clinical guidelines and protocols' (Armstrong, 2002: 1772). Consequently the restratification thesis focuses upon developments such as the growth of co-opted medically qualified managers who are charged with controlling the surveillance and evaluation of medical work. The key question it seeks to answer is whether these new developments protect the general public whilst also maintaining collective self-regulatory privileges in a new form (Harrison 2004)?

It is undoubtedly the case that the proletarianisation, deprofessionalisation and restratification theses possess a great deal of analytical value (Elston, 1991). However, systematic supportive empirical data remains sparse (Coburn and Willis, 2000). Published academic research tends to focus upon reforms in the health care system affecting the ways in which clinical judgements are made, with too little attention given to the key role played by who controls the process and quality control of medical education in ensuring the continued legitimacy of broader occupational control over regulatory arrangements (Ahmad and Harrison, 2000, Sheaff et al., 2004). Yet the 'shoring up' of professional training due to the presence of external threats to occupational control over self-regulatory privileges logically forms an important part of the restratification thesis (Elston, 2004). It certainly would be reasonable to assume that elite members within professional groups will attempt to retain control of the use and interpretation of their specialist knowledge through submitting rank and file members to formalistic methods of surveillance and control within the educational as well as the everyday practice context (Waring, 2007). Consequently, current developments such as the introduction of revalidation serve to reinforce the need to undertake a dedicated research programme into doctors' educational practices, in order to obtain a clearer and more rounded picture of the full impact of the current regulatory reform agenda. This process may have started over the last decade with social scientists increasingly being 'invited in' to conduct research into medical curricula as a result of recent reforms in undergraduate medical education (e.g. Gray and Harrison, 2004). However, arguably, more far-reaching and sustained access is needed to enable social scientists to make a thorough and theoretically informed evaluation of the short and long term effects of the current regulatory reform agenda upon medical autonomy.

In conclusion, recent reforms to medical governance highlight the fact that social scientists are perhaps guilty of paying too little attention to doctors' educational activities, particularly how they keep themselves up to date and 'fit to practice' in their chosen specialty. Yet they also provide an opportunity to rectify this situation. There is a clear need to analyse changes in the nature and extent of the educational autonomy possessed by rank and file medical practitioners through undertaking a detailed and close examination of the implementation of revalidation and concurrent reforms to NHS appraisal. This will help to develop a clearer picture of what the future may bring in regard to how the experts who provide us with much valued public services can be regulated to ensure the welfare of the general public. Perhaps most importantly it may also mean that another Shipman will not be allowed to creep through the cracks.

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