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Through the Looking Glass and What the Doctor Found There

Medical regulation: on the critical list

Christoph Lees & Hilarie Williams

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Hilarie Williams has a special interest in the social history of medicine and the development of health policy. She graduated in medicine in 1978 and, in 1987, joined the fledgling AIDS unit at the (then) DHSS. Over the next 16 years, Hilarie worked in various health policy areas and she was Senior Medical Adviser to the Department for Education and Employment from 1994 to 2000. She currently combines part time work in medical research with being a carer and she is active in voluntary sector support for people with learning disabilities and autism. Hilarie has studied humanities with the Open University and was awarded an MSc (distinction) in the History and Philosophy of Medicine, Science and Society by Birkbeck College (University of London) in 2011. She continues to enjoy exploring historical perspectives of medicine, the medical profession and health policy.

Christoph Lees has taken an interest in medical regulation, healthcare funding and access to high cost treatments. He was a founder member of Doctors for Reform (2002-2012) and the Civitas Doctors' Policy Research Group (2013), and was Chairman of the Local Negotiating Committee at Addenbrooke's Hospital, Cambridge, 2011-2013. He has informally and formally mentored many doctors who underwent disciplinary and other procedures and assessments. Christoph is a Consultant in Obstetrics & Fetal-Maternal Medicine in London and Visiting Professor at KU Leuven, Belgium. He trained at Guy's, King's College and St George's Hospitals in London and obtained subspecialty accreditation at the Harris Birthright Centre for Fetal Medicine. He has authored Pregnancy Questions and Answers (Dorling Kindersley 1997, 2001 & 2007), Making Sense of Obstetric Doppler (Arnold 2002) and has 120+ research papers in prenatal diagnosis and ultrasound. He runs practical and theory courses in ultrasound and fetal medicine in the UK and abroad in locations such as Peru, El Salvador and India.

CIVITAS
55 Tufton Street, London SW1P 3QL
T: 020 7799 6677
E: info@civitas.org.uk

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Introduction

Much has happened in the six months since our report for Civitas "The General Medical Council: Fit to Practise?" was published.[1] A wider understanding is dawning about the effect of oppressive regulatory culture on doctors and, perhaps, the likely knock-on effect on patients. It has been fostered by two publications: the GMC's report on deaths in doctors under investigation[2], and Bourne and colleagues' survey of nearly 8,000 doctors which provided detailed information about the impact of complaints on doctors' health and the way they practise medicine[3]. Understanding has also been amplified by the latest data on 'fitness to practise' complaints and their outcomes.[4] On current form, all doctors can expect to face at least one fitness to practise investigation in their career. For doctors in some specialties this might be several. The disruption to their personal and professional lives will be immense. But it is a grossly disproportionate system: from 2010 to 2013 only 17% of over eight thousand investigations led to any kind of sanction or warning; only 0.1% of some eighteen and a half thousand complaints from the public resulted in a doctor being struck off or even suspended temporarily from the register. The latest data have led us to question yet again how such a heavy handed approach can be justified.[5]

Two deaths per month from all causes

In December 2014, the GMC issued Sandrah Horsfall's report on deaths in doctors undergoing fitness to practise procedures. This was welcome, though we think it likely that the report only scratches the surface of ill health engendered or exacerbated by GMC processes as it was confined to confirmed suicides, not deaths aggravated by investigation, and only those occurring while an investigation was 'open and disclosed'. Reaction from working doctors [6] supports the view that there is something seriously wrong with a fitness-to-practise system that, in 2013, was associated with one confirmed or suspected suicide every 6 weeks[7] and with nearly two deaths per month from all causes in doctors with an open fitness to practise case.[8]

The GMC is to review its procedures in relation to 'vulnerable' doctors[9] but is this adequate? Giving evidence to the Commons Health Select Committee's accountability review in January 2015, the GMC chief executive stated 'the doctors who are under investigation come into investigation because … they have very serious mental health problems' [10]. Our experience of mentoring and feedback from many investigated doctors (some who have been vindicated by appeal court

judgments) is that the majority were not 'vulnerable' when the first GMC envelope dropped onto their doormat but almost all became so during the course of investigation. The protracted, adversarial nature of the process, the menace to professional identity and self-worth and the threat of public humiliation can break even the most confident. This may be compounded by the lack of analytical and medical expertise being applied to their case by the regulator.[11] A third of 28 suicides identified by Horsfall had been under investigation for over 2 years. Four doctors had been in the process for over 5 years.[12] The new chair of the GMC accepted that all doctors can now expect to face disciplinary proceedings at some point. He reiterated the GMC's solution - doctors need 'emotional resilience training'. The chairman likened the situation to preparing soldiers before they are sent to Afghanistan. Aside from the lack of evidence for the efficacy of 'emotional resilience training' in the military, this seemed worryingly incompatible with calls for doctors to show compassion to others or for them to demonstrate insight into their failings. Our impression that GMC top brass 'just don't get it' was bolstered by the GMC chairman's conviction that any rise in defensive practice reflected litigation, not any fear of the GMC and his belief that the revalidation process is not encouraging experienced doctors to retire. As Charlotte Leslie MP remarked about the reported enthusiasm for revalidation 'You have spoken to some rather different doctors to the ones I spoke to'.[13]

The chair of the GMC has certainly spoken to different doctors from the 7,926 registered medical practitioners who informed Professor Tom Bourne's recent paper in BMJ Open. Bourne found that all types of disciplinary action, but particularly GMC complaints, resulted in an increase in 'hedging' activities and had a profound effect on doctors' mental and physical health. In a detailed justification of the GMC's position posted in response to the Bourne paper [14] the Council's Chief Executive conceded that referral to a regulator is stressful-and that 'creating a quick and simple complaints process …must be a matter for the health system as a whole'. This apparently cooperative approach to complaints is hard to reconcile with recent signs of the GMC wanting to extend its own role and powers.

Doctors could be deprived of their livelihoods on the basis of undefined 'concerns'

In August 2014 the GMC consulted on a substantial package of proposals that would, amongst many other things, enable them to 'sanction' doctors against a new criterion, that of 'maintaining public confidence' in the absence of there being

any plausible risk to patients.[15] A parallel consultation by the Department of Health[16] paved the way for the necessary statutory change. Some might argue that this is what the GMC does anyway – for example when doctors have had a criminal conviction that is wholly unrelated to their medical competence. But the new proposal would potentially legitimise the GMC and their Medical Practitioner Tribunal Service (MPTS) depriving doctors of their livelihood on the basis of a potentially infinite variety of undefined 'concerns' including aspects of their private lives. The same consultation dwelt on requirements for doctors to mitigate their case through demonstrating 'insight' and apologising. This raises a spectre of forced public confession and self-flagellation and builds on the pressure to accept warnings or agree consensual disposal to avoid a public hearing. The latter is now being vaunted by the GMC as a positive action to alleviate the stress on doctors[17] but that completely ignores the deficiencies of the investigatory system. As only a 51:49 balance of probability is used to test their decision-making there can obviously be a substantial chance that a 'convicted' doctor who denies their guilt is actually correct and the GMC case examiners and/or MPTS panel are wrong. This Kafka-esque situation might make a doctor feel coerced into throwing himself on his sword and accepting a minor sanction in order to avoid the risk of being struck off for failing to show insight. In this context, showing 'insight' seems to be most appropriately defined as agreeing with the GMC and showing no insight as disagreeing with the GMC. Another sinister proposal was that doctors could be sanctioned for failure to raise concerns within their employment. This could impose a vicarious liability on doctors for general system failures beyond their control. The likelihood of unintended consequences for the NHS must be extremely high.

Might this last proposal be linked to another new way of working for the GMC? The GP magazine PULSE reported last week that the GMC and CQC have put in place arrangements for joint inspections of GP practices. The chair of the BMA General Practitioners Committee contracts and regulation subcommittee, is quoted as saying that this is 'a very worrying development which gives opportunity to inappropriately conflate issues related to professional performance with those of provider regulation'.[18] This does not seem to be the only area of 'mission creep'. The GMC already has an extensive system of support for complainants.[19] It is now introducing meetings - at the beginning and end of an investigation - in which what the GMC can and cannot do is clarified for complainants. In evidence to the January 2015 hearing of the Health Select Committee, the chief executive said 'It is

also an opportunity ... to hear directly and in an informal way what the complaint is ... people are saying "*It is the first time anybody has spoken to me, never mind just the GMC, but the NHS or anybody, and actually listened to what I am trying to say*." That bit is hugely positive … We are not a body that can provide redress for complainants, but we can be a body that genuinely listens to people'.[20] So what's not to like? Setting aside the potential scale of this operation (over 3,000 investigations per year with two meetings offered plus expenses for a 'supporter') and any possible prejudice to the investigation process, it appears that the GMC has taken on a therapeutic role. Is that appropriate for a regulator of basic standards? It sits oddly with the GMC chairman's belief that doctors whose lives are torn apart unjustifiably by GMC processes should just 'man-up'.

Everything points to the need for a fundamental appraisal of what really matters

Where does all this leave us? We have a seemingly unstoppable regulation industry, now with regulators joining hands in a way never previously envisaged. We have almost a perfect storm with evidence of the complaint processes itself negatively affecting patient care and a crisis in doctor recruitment and retention – particularly in General Practice and Accident and Emergency services.[21] There are burgeoning numbers of complaints to the regulator, most of which come to nothing but often only after protracted and expensive investigation that may impact seriously on the doctor's health and livelihood. The GMC chief executive acknowledges that the rise does not reflect diminishing standards but raised expectations. But, rather than state baldly to their parliamentary overseers that it is time that politicians stopped encouraging unsustainable expectation, the privy council appointees who sit on the General Medical Council appear to want to extend their organisation further and further into doctors lives, embracing a role far removed from the council's original purpose.

We do not question that some structures are needed to protect and safeguard patients but there is little evidence in favour of current ones and much against them. The GMC is being inundated with complaints that it does not pursue because they are at best misdirected and at worst vexatious. Less than a fifth of those they do pursue lead to a sanction or warning. A representative of 'NHS Employers' interviewed for GMC commissioned research remarked of doctors 'you treat them the same way you might treat, you know, a mechanic or trade person'.[22] The GMC chief executive is arguably more diplomatic when he welcomes the fact

that 'doctor no longer knows best' [23] but, given these perspectives, there are serious questions to be asked about the nature of 'professional' regulation that is required. Everything points to the need for a fundamental appraisal of what really matters in a system where there are significant constraints on financial resources and on the supply of expensively trained doctors and allied professionals. It points to the desirability of a single system for investigating concerns about healthcare. It does not point to more and more guidelines and a raft of regulatory bureaucracies so complex that the GMC is sprouting another head to mollify complainants who feel they have been given the run-around. The need for a streamlined complaints process seems to be supported by the GMC chief executive. Problems with existing systems have been recognised by the House of Commons Public Administration Select Committee and we hope that action may proceed from their current enquiry.[24] But before any new quango is created, public debate needs to go beyond structures and delve into difficult issues such as what a state healthcare system can be expected to deliver, what the incentives are for being excellent if the focus is on rooting out the worst, and what is the appropriate balance of rights and responsibilities between those who provide and those who receive healthcare.

Endnotes

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14 Dickson N. qv.

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