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Regulating the Medical Profession: From Club Governance to Stakeholder Regulation

Abstract

The 2008 Health and Social Care Act introduced reforms in the regulation of the medical profession in the United Kingdom which have arguably challenged medical autonomy in the form of the principle of medical self-regulation through introducing performance surveillance and appraisal mechanisms designed to ensure medical practitioners are 'fit to practice' in their chosen speciality. This paper outlines these developments, arguing as it does so that there has been a shift in the governance of medical work from the traditional 'club governance' model toward one based upon 'stakeholder regulation'. The consequences of this state of affairs are discussed and possible research avenues highlighted in light of the proposed introduction in 2011 of the performance appraisal process known as revalidation.

Keywords: Annual Appraisal, Medical Autonomy, Medical Self-Regulation, Medical Profession, Performance Appraisal, Revalidation

This paper is concerned with recent developments in the regulation of the medical profession in the United Kingdom. It outlines changes to the General Medical Council (GMC) and in the surveillance and performance management of medical work brought about by the 2008 Health and Social Care Act. In doing so it highlights an important new research avenue for sociologists interested in the regulation of professional forms of expertise. It is divided into three sections. In the first the paper

discusses the 1858 Medical Act and the traditional 'club governance' model of medical regulation. It then explores the 2008 Health and Social Care Act and the contemporary shift toward 'stakeholder regulation'. The paper concludes by arguing for the need for social scientists to conduct research into the introduction of the performance appraisal tool known as revalidation.

The 1858 Medical Act and Club Government

'In 1858 the GMC was effectively a gentlemen's club. Its promise that the public could trust those it registered amounted to ensuring that there were no 'bounders' in the medical fraternity [sic] who would do dastardly things such as no gentleman would do…'.
Stacey (1992: 204)

The medical profession in the United Kingdom is regulated by the GMC. The GMC was founded by the 1858 Medical Act which granted the profession control over entry onto and exit from a legally underwritten register of state approved medical practitioners. The GMC's two key responsibilities are to maintain a register of qualified medical practitioners and to define the nature of the qualifications necessary to obtain registration. It is commonly argued that medicine's altruistic principles and close association with science naturally led to its being granted the privilege of professional self-regulation (i.e. Irvine 2003). However the GMC did not come into existence within in a socio-economic and political vacuum. Indeed both Stacey (1992) and Moran (1999, 2004) have been at pains to point out that broader social circumstance shaped the nature of the institutional arrangements surrounding the

establishment of the GMC. The 1858 Medical Act may well have been designed to regulate the burgeoning health care marketplace and to generate public trust in the competence of medical practitioners. But both it and the GMC it gave rise to were nevertheless reflections of the essentially pre-democratic, oligarchic, political structure of the time (Gladstone 2000). As Moran (2004: 28) notes *because government was the product of an era of oligarchy, deference and social elitism it was the government of clubs…[and] the government of doctors was patterned on the club system'*. He cites Marquand (1988: 178) who says of the ideology of the broader Victorian governing style that *'[the] atmosphere of British government was that of a club, whose members trusted each other to observe the spirit of the club rules, the notion that the principles underlying the rules should be clearly defined and publicly proclaimed was profoundly alien'*.

In line with the club governance model medical elites such as the royal colleges and medical schools exclusively controlled the GMC, and so access to and from the state register of approved practitioners, and in doing so protected medical autonomy in the form of the principle of professional self-regulation from outside surveillance and control. Medicine's lack of transparency and accountability arguably continued for the next hundred and fifty years until the 2008 Health and Social Care Act (Chamberlain 2010). However in response to a series of high profile cases - such as the general practitioner and mass murderer Dr Harold Shipman who killed over two hundred and fifteen of his patients – in the last decade the state intervened and sought to 'open up' medical regulation and make it more transparent and publicly accountable (Davies 2004). Indeed as the paper will now discuss on the surface it

appears that the 2008 Health and Social Care Act has significantly reduced the stranglehold medical elites have traditionally possessed over the GMC.

Stakeholder Regulation and the 2008 Health and Social Care Medical Act

It would be misleading to say that medical control over the GMC went completely unchecked. Particularly as rapid social and economic changes from the 1960s onward increasingly brought about the questioning of traditional forms of authority (Moran 2004). Certainly a series of high profile medical malpractice cases reinforced that greater inter-professional cooperation and managerial and lay involvement in the regulation of professional expertise was urgently needed (Gladstone 2000). For example, the Royal Bristol Infirmary case saw several children die due to botched procedures which the surgeons involved tried to cover up. Cases such as Bristol reinforced to medical elites such as the royal colleges that they needed to adopt more open and transparent governing regimes which included all the stakeholders involved (Davies 2004, Irvine 2006). They established clear standards which could be operationalized into performance outcomes against which the 'fitness to practice' of members of the profession could be regularly checked (Black 2002, Irvine 2003). The rise of stakeholder regulation was bound up with the emergence of a 'new medical professionalism' (Irvine 2006). As the chairman of the GMC of the time, Donald Irvine, noted (2001: 1808), *'the essence of the new professionalism is clear professional standards'*.

These reforms did not go far enough for many victims of medical malpractice. **Yet it was not strictly a medical malpractice case, but rather an instance of a**

doctor possessing criminal intent, which can be said to have engendered fundamental change in the governance of medical expertise (Chamberlain 2000). The general public was morally outraged by the case of Harold Shipman, the general practitioner from Hyde in Manchester who was able to use his position to murder two hundred and fifteen of his patients, and furthermore, seemed to have enjoyed the protection of the GMC. That is at least initially when his case first came into the public eye (Stacey 2000). Many an impartial onlooker, let alone the relatives of Shipman's victims, was repulsed by the fact that it was not until well after his conviction that the GMC finally struck Shipman off the medical register and admitted that a decade earlier he had in fact come before its fitness to practice panel for prescription abuse (Gladstone 2000).

Undoubtedly the Shipman case played a pivotal role in reinforcing the need to end medical control of the GMC (Chamberlain 2010). Indeed Smith (2005: 1174) at the end her governmental review of the Shipman case, was '*driven to the conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors lingers on*'. 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*" (Smith 2005: 1176). In 2007 the Health and Social Care White Paper was announced as a direct result of the Smith's 2005 report. This passed through parliament as the 2008 Health and Social Care Act. The 2008 Act introduced two key reforms in medical regulation. First, non-medical 'lay members' now have to make up half of the GMC membership, while all new members are

elected via an independent system overseen by the Public Appointments Commission. Furthermore the GMC lost its power to adjudicate on fitness-to-practice cases. Traditionally such cases have been judged on the criminal standard - beyond all reasonable doubt. A situation which has frequently led commentators to argue the GMC's disciplinary procedures have first and foremost protected underperforming doctors instead of members of the general public (i.e. Allsop 2006). But now fitness to practice cases are to be judged on the civil standard of proof - on the balance of probability – which it is hoped will enable underperforming doctors to be more easily stopped from continuing to practice.

The second key part of the 2008 Act was the introduction of what is to be known as a 'GMC affiliate' within National Health Service (NHS) accountability structures at a local level. The affiliate will coordinate the investigation of complaints at a NHS trust level. The affiliate will also work with the royal colleges concerning the arrangements for ensuring 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). 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) felt that as it currently operates appraisal would not have identified Shipman and does *not offer the public protection from underperforming doctors'*. Appraisal still occurs annually but there will be 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 complete 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, by the relevant royal college, of their '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 activates, will together ensure specialist recertification (Donaldson 2008). Relicensing and specialist recertification elements of the revalidation process were initially planned to be introduced by 2010, but there has been a slight delay and revalidation will now be formally introduced nationally from mid-2011 onwards.

Expert Systems and the Service Ideal

'Expert systems bracket time and space through deploying modes of technical knowledge which have validity independent of the practitioners and clients who make use of them. Such systems penetrate virtually all aspects of social life in conditions of modernity – in respect to the food we eat, the medicines we take the building we inhabit, the forms of transport we use…..[but they] depend in an essential way on trust'.
Giddens (1990: 18)

There can be no doubt that over the last three decades there has been a cultural and organisational shift within the health and social care context toward emphasising professional accountability (Davies 2004). Indeed medical elites themselves argue that the emergence of stakeholder regulation signifies a 'cultural change' towards a more transparent and contractually binding regulatory relationship between medicine

and the public (i.e. Irvine 1997 2003, Catto 2006 2007). Yet contemporary developments are often criticised in a somewhat knee jerk fashion by 'rank and file' health care professionals as providing prescriptive procedures and rules in the form of protocols and guidelines to be blindly followed without question (Chamberlain 2009). There is a feeling of disquiet within the medical profession with what is ultimately seen to be a politically motivated and unrealistic tendency on behalf of government to minimise clinical risk by turning medical work into a series of routine 'step by step' rules and procedures against which individual clinician performance can be measured (Harrison 2004). Because for many this 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. Certainly many medical practitioners would argue that these situations are decidedly different from the sanitised world assumed by clinical guidelines and protocols. It is no wonder therefore that regardless of their views about how it should be undertaken and by whom, many if not all doctors claim that some form of professionally led medical regulation is both necessary and in the public interest.

Eliot Freidson has repeatedly highlighted over an academic career spanning four decades that the need for doctors to exercise discretion in their work is an issue which is unlikely to disappear as long as people need and want to see a doctor to help them cope with illness and disease (Freidson 1970 1994 2001). Indeed in his latest work Freidson (2001) has moved away from his earlier more critical view of medical autonomy (i.e. Freidson 1970). He insists that doctors must be allowed to exercise discretion in their work due to its inherently specialist nature, the tacit-indeterminate foundations of medical expertise, as well as the emphasis medicine collectively places

upon providing a community service through promoting public health. He holds that non-medical external regulation of medical work is not always possible or in the public interest. He outlines three methods of regulatory control – 'Bureaucracy', characterised by managerial control, 'The Market', characterised by consumer control, and 'Professionalism', characterised by occupational self-control (Freidson 2001). He discusses how in the last two decades greater managerially led 'Bureaucracy' and a concurrent increase in the rule of 'The Market' have successfully challenged 'Professionalism', with the doctors increasingly losing the right to exercise discretion in their practice. In particular he notes that patients are unwilling to adopt the subservient position medicine has historically accorded them. Patients nowadays frequently see themselves as active health care consumers. Additionally there has been a rise in managerial control over clinical practice through the increased use of standardised administrative procedures, in the form of clinical guidelines and protocols. These exist under the banner of supporting greater patient choice while also improving productivity. Freidson (2001: 181) argues that *'the emphasis on consumerism and managerialism has legitimised and advanced the individual pursuit of material self-interest....the very [vice] for which professions have been criticised'*. In summary, while previously an ardent critic of the high level of autonomy granted to medicine to control its own affairs, Freidson (2001) now emphasises the positive moral role professions such as medicine can and do play in society. Like Stacey (1992 2000) before him he holds that the moral code of public service inherent in the concept of professionalism can act to dispel what Wilson (1990: 147) called *'the ethical vacuum of the 'postmodern' society'*. He argues that health practitioners themselves, not patients and managers, must ultimately control their work activities. **Not least of all because the nature of their knowledge demands that society**

recognises professionals must possess *'independence of judgement and freedom of action' (Freidson 2001: 122).* Although he recognises that this may not be to everybody's taste, he calls for a revival of the 'ideology of service' and claims that professional monopolies are *'more than modes of exploitation or domination they are also social devices for supporting growth and refinement of disciplines and the quality of their practice'* (Freidson 2001: 203).

Sociologists like Stacey (1991 2000) and Freidson (1994 2001) echo the common view amongst professionals that it is not the principle of professional self-regulation that in itself is unjustifiable. It is only particular instances where it has been abused. Professionals must now work with the public to make sure such abuses do not happen again (Irvine 2003 2006). The emergence of stakeholder regulation and the advocacy by medical elites of a 'new professionalism' is an attempt to establish a new contractual relationship between the medical profession and the public against the background of increasing government intervention into the field of medical regulation (Slater 2007). **Recent moves to change in the field of professional regulation reinforce that effective medical regulation, similar to the effective delivery of health care, requires the cooperation and proactive involvement of individual medical practitioners and their elite institutions**. This is because contemporary challenges to professional autonomy bring 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: 220).

Conclusion: Researching Revalidation

It is the dynamic nature of this need to both nurture and control professional expertise which has led to the royal colleges and medical schools being allocated a significant role in developing and implementing new performance appraisal tools such as revalidation. It is also why medical control over entry onto (via medical school and junior doctor training) and exit from (via appraisal of their continue competence) the legally underwritten state approved register of practitioners will continue for the foreseeable future. Not least of all because the state does not want the GMC to be completely abolished. It is, after all, a self-funding body paid for by doctors themselves. While peer assessment is still acknowledged, by both medical and non-medical observers alike, as the essential core method by which an individual doctor's clinical competence can be legitimately assessed and underperformance addressed (Irvine 2003, Catto 2006 2007, GMC 2008). Indeed the Health and Social Care Act 2008 may well propose managerial, patient and inter-professional involvement in revalidation when it is finally implemented at a national level in 2011. Yet the revalidation process will nevertheless be organized and quality assured by the royal college relevant to a particular medical speciality, operating in tandem with the GMC and NHS management (Chamberlain 2009).

The Health and Social Care Act of 2008 did however put into place significant checks and balances to medical control over doctors activities. As this paper has already noted, the GMC will be made up of an equal number of lay and medical members, all of whom will be independently nominated by the Public Appointments Commission. While in spite of medical elite campaigning, the burden of proof

required in fitness to practice cases has been lessened from criminal standards – i.e. beyond all reasonable doubt – i.e. to civil standards - on the balance of probability. Consequently the current 'state of the field' surrounding medical regulation appears significantly different to what it was a decade or so ago, let alone one hundred and fifty years ago when the GMC was first established. The GMC is more open and publicly accountable than it ever has been (Allsop 2006). Yet the issue of the specialist nature of professional expertise, alongside the concurrent need for professionals to exercise discretion in their work, does create a 'buffer zone' that protects doctors from outsider surveillance and control (Freidson 2001). **Freidson (1994) argued via his restratification thesis that medical elites were increasingly exploiting this buffer zone as they sought to maintain some semblance of medical autonomy through subjecting 'the rank and file doctor' to greater surveillance and control mechanisms. Revalidation is arguably the latest example of this approach (Chamberlain 2010).** There will no return to the 'closed shop' era of club governance. Indeed medical elites must now increasingly advocate a transparent and inclusive governing regime under the ever-watchful eye of the state. Nevertheless doctors still possess significant amount of freedom to control their own affairs, particularly when compared to other occupations. The current situation concerning the governance of medical expertise is therefore perhaps best summed up by Moran (1999) who argues that: *'...states are more important than ever before, either in the direct surveillance of the profession or in supervising the institutions of surveillance...[this] has not necessarily diminished the power of doctors; but it has profoundly changed the institutional landscape upon which they have to operate'* (Moran 1999: 129-30).

In conclusion given the events discussed in this paper it clearly important for social scientists to engage in a dedicated longitudinal research programme concerned with the implementation of new regulatory quality assurance tools such as revalidation. Not least of all because the limited empirical research which currently does exist concerning similar performance monitoring and appraisal mechanisms to revalidation, such as annual NHS appraisal for example, reinforces that there is a tendency for doctors to engage in paperwork compliance toward regulatory tools designed to survey and quality control their performance in an open and transparent manner, due in no small part to the inherent tensions that exist between the formal and tacit foundations of medical expertise (see Chamberlain 2009 for greater detail). Clearly this is a research area within which social scientists could use their own expertise to help medical elites strike a balance between protecting medical autonomy and ensuring medical work remains open to a necessary element of surveillance and control in order to protect the general public from poorly performing doctors. After all medicine is not the only profession that possesses a strong public service ideal.

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