
Governing
UK medical performance: a struggle for policy dominance

Brian Salter
brian.salter@uea.ac.uk
University of East Anglia
www.globalbiopolitics.org
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Introduction
In the UK, policy on the governance of medical performance is characterised by a continuing struggle between state and profession for control of the agenda setting, formation and implementation stages of the policy process. Since 1998 both sides have continued to produce policies in response to highly visible political pressures but have yet to agree on how those policies should engage as they are implemented at the level of the individual practitioner. For the state, clinical governance forms the lynchpin of its drive to increase managerial control over doctors and, for the profession, revalidation is seen as the means for ensuring the quality of medical performance whilst preserving medicine's historic autonomy. Both policies aim at addressing the central political issue of the protection of the patient and the decline in the public’s trust in doctors. As yet, neither state nor profession has achieved a lasting dominance of this arena of policy making.

In constructing and delivering policy, state and profession draw on quite different sets of institutional structures and values. Together the Department of Health (DoH) and National Health Service (NHS) constitute a political-bureaucratic hierarchy that assumes that policy can be centrally formulated and locally delivered according to a uniform pattern. The profession, on the other hand, is made up of a network of loosely allied institutions formally headed by the General Medical Council (GMC), bound together by historic and informal understandings, that readily compete with each other for a share in any new territory of performance governance. Then there are health consumers and the market, increasingly a part of the policy rhetoric (particularly that of the government), but, with the continuing separation of state and private medicine, yet to become serious players in the policy process.

The purpose of this paper is to analyse the implications of this struggle for the construction of policy on the governance of medical performance. It begins with the policies themselves. What were the initial components of the clinical governance and revalidation policies? Secondly, what is the nature of the pressures that have given rise to this lengthy period of policy invention and why have they generated such a
sustained policy momentum? Thirdly, how did the policies evolve as a result of these pressures and what does this tell us about the impact of these pressures on the parallel systems of policy formation of state and profession? To what extent have institutions and their values created a path dependency that maintains the policy separation of state and profession?

The policies

Clinical governance
In April 1998 it was announced that ‘for the first time in the history of the NHS’ hospital Trusts were to be held legally accountable for the quality of the service they provided [1]. (The requirement was subsequently given statutory force by the Health Act, 1999.) In the consultation document A first class service: quality in the new NHS which followed this announcement it was made clear that what was proposed was a management-led system of clinical governance designed to set and monitor clinical standards [2]. Its definition of the new managerial concept of clinical governance was of ‘a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’ (p. 33) [2]. Self-regulation remained, at least in name, but the document notes that if the public confidence in doctors so seriously dented by events such as those at Bristol Royal Infirmary is to be restored, self-regulation must be modernised. It must be situated within a state-administered apparatus of accountability to ensure that it is ‘open to public scrutiny; responsive to changing clinical practice and changing service needs; and publicly accountable for professional standards set nationally and the action taken to maintain those standards’ (para. 3.44) [2]. Furthermore, if necessary (and, one assumes, should the profession prove uncooperative), clinical governance ‘will provide a systematic framework that can be extended into the clinical community at all levels’ (para. 3.12) [2].

Here we have the rationalistic bureaucratic discourse of regulation which reveals itself through increasingly extensive rule systems, the ‘scientific’ measurement of objective
standards, and the minimization of the scope for human error. Behind it lies a faith in the efficacy of surveillance as a directive force in human affairs. As such, in terms of its understanding of the principal dynamic in the maintenance of clinical standards, the bureaucratic discourse is the ideological opposite of the belief in the self-sustaining individual professional (or group of professionals) who is motivated ‘by the sense of self-respect that flows from doctors’ ownership of professional standards’ (p. 1177) [3].

Perhaps the bravest statement in this opening policy formation salvo on medical performance was that ‘Government will take responsibility for clarifying which treatments work best’ (para. 2.27) [2]. By proposing to take ultimate responsibility for clinical standards, a key area in the control of medical knowledge, the state was making crystal clear its ambition to gain sovereignty over regulatory territory that had traditionally been the province of the profession. However, as the policy technicians began to work out how the policy of clinical governance might be implemented, and thus a realistic challenge to medical dominance of this health policy field mounted, the extent of its complexities began to emerge. An initial problem was that the actual process of clinical governance was not defined in the early policy statements which had focused instead on its intended output of enhanced service quality. Thus, clinical governance was at various times taken to include medical audit, clinical audit, critical incident reporting, adverse event reporting, risk management, annual appraisal, and quality assurance – in other words, anything which could be understood to maintain and improve clinical standards. Structures and theoretical responsibilities were easier for the policy technicians to deal with and can be summarised here in terms of their intended governance functions of standard setting, monitoring and intervention [4]. In somewhat cavalier style, responsibilities for these functions were allocated as follows: for standard setting, to the National Institute for Clinical Excellence (NICE) and the National Service Frameworks (NSFs); for monitoring and evaluation, to the Health Authorities (HAs), Primary Care Groups (PCGs), the National Health Services Executive (NHSE), the Commission for Health Improvement (CHI), the NHS Performance Assessment Framework and the National Patient and User Survey; and for intervention, to the previous list for evaluation plus the provider hospital and primary care Trusts themselves. (p. 4) [5]. Regrettably, no-one knew how these
different structures and their overlapping functions were intended to interrelate. There was no coordinating system of accountability.

The Department’s *Supporting doctors, protecting patients*, a consultation paper produced in November 1999, shows in graphic detail the extent of the state’s exposure at this time. In blissful ignorance of what was to come the document cites two cases which ‘can be regarded as a watershed in the history of poor clinical performance in the NHS’ (a statement which is in itself a powerful indicator of the formative capacity of particular issues): the Bristol children’s heart surgery service and the gynaecologist dismissed by South Kent Hospitals NHS Trust because of serious failures in his clinical practice (Mr Rodney Ledward, the subject of an inquiry chaired by Miss Jean Ritchie QC). As the document admits, the main difficulty in developing an NHS policy, clinical governance or otherwise, to deal with such cases was the absence of any obvious starting point:

Present NHS procedures for detecting and dealing with poor clinical performance are fragmented and inflexible. There is a strong impression that some doctors who are performing poorly are slipping through the net because employers are not willing to use daunting disciplinary procedures, because it is difficult to hold the employee to account or because no adequate procedures exist, because other health professionals are reluctant to report a colleague’s problems, or because the systems to detect poor performance or underlying ill health are just not adequate. (para. 2.55) [6].

And, it can be added, the procedures which do exist are largely controlled by doctors [7]. In a sense this is what one would expect. Given that the role of NHS management had never before included the monitoring of clinician performance, since this was understood to be the province of self-regulation, management driven performance procedures were superfluous to the historic understanding of how the Health Service worked.

*Supporting doctors, protecting patients* marks the point at which the self-belief of the Labour government in its ability to use management action as the sole means of affecting change in the governance of medical performance began to be undermined.
(It is significant that the consultation document was produced under the aegis of the Chief Medical Officer (CMO) who acts as a bridge between state and profession.) As the document’s long list of measures requiring the coordination of state and professional procedures to prevent as well as identify poor performance illustrates, a recognition of the significance of medical power had returned. Clinical audit, continuing professional development, linkage between appraisal and the employment contract, and assessment and support centres for doctors run jointly by the NHS and the medical profession were some of the areas addressed. Clearly for both the state and medicine there was a large agenda to take forward.

Revalidation

Meanwhile the profession had not been idle. Although recognising that reform was necessary, the initial policy suggestions from the numerous institutions of medicine (Medical Royal Colleges, specialist associations and so on) asserted that the existing system for the profession’s regulation of its own medical performance simply need to be updated and improved for, as the Central Consultants and Specialists Committee of the BMA (CCSC) put it, ‘the quality of medical practice is ultimately guaranteed by professional self-regulation, and it is therefore appropriate for the profession itself to respond to clinical governance by showing that self-regulation can work locally as well as nationally’ [8]. However, in February 1999, the GMC seized the policy initiative with its decision that, ‘to maintain their registration, all doctors must be able to demonstrate regularly that they continue to be fit to practise in their chosen field’ [9]. As a political concept, ‘revalidation’ had been launched. The Report of the revalidation steering group on which this decision was based proposed a six-stage process incorporating all the three functions of governance: standards setting, monitoring and evaluation, and intervention. The stages were: local profiling of performance; periodic external peer review of the profiling process; providing evidence that would lead to revalidation of the doctor’s entry in the register; (and where there are concerns about a doctor’s performance) local remediation; referral to the GMC performance procedures; action by the GMC on the doctor’s registration [10]. The policy agenda had been set, but would it be developed further?
By taking the revalidation step the GMC signalled to both the elites of medicine and to the state that it was attempting to change its role from that of a contributor to self-regulation to one where it had a coordinating function across all parts of self-regulation. Clearly such a shift raised serious questions in the minds of the other medical elites, particularly the Royal Colleges. How would their regulatory territory and hence their power base be affected by the GMC’s ambition of an explicit linkage between the governance functions of standard setting, monitoring and evaluation and intervention? What should be their contribution to the revalidation process and how should this be decided? In any case, did the Council possess the authority and legitimacy to carry through its plan particularly given that it was simultaneously engaged in constitutional reform?

An important player in the initial progress of the revalidation policy was the Academy of Medical Royal Colleges (AMRC), effectively a political broker of medical interests. To stimulate a debate on the way forward, the Academy issued its own consultation document on revalidation which supported the GMC’s general direction but presented five organisational models of how revalidation might be implemented (AMRC, 1999). At the same time, the Council engaged the Medical Royal Colleges in the details of how the revalidation policy might be implemented by asking them to elaborate for their own specialties and for general practice the application of the principles contained in Good medical practice – the GMC’s statement of the duties and responsibilities of a doctor [11]. By April 2000, discussions had progressed to the point where the Revalidation Leads Group of the AMRC (representative of all the College and Faculty interests) was able to issue the tactfully titled document How the Royal Colleges and Faculties might contribute to the process of revalidation, a joint statement establishing a common format for the Colleges’ input to revalidation and thus a common political position on the regulatory territory which should remain in their hands [12].

With the major issues regarding which medical institution should do what in the revalidation process apparently identified and under negotiation, in June 2000 the Council produced the document Revalidating doctors for consultation as it sought to consolidate its grip on the revalidation policy formation process [13]. Within this document we can see not only the provisionally agreed contribution of the Medical
Royal Colleges and specialty associations to revalidation but also the possible contribution of the state and patients’ organisations. Having seized the policy initiative within medicine, the Council now aimed to integrate into its revalidation framework the contribution of: annual appraisal as part of doctors’ NHS contracts, local management processes under clinical governance, and the work of bodies such as the Commission for Health Improvement (CHI) (box 5) [13]. In other words, the GMC’s ambition was to coordinate the policy moves of the state, as well as those of the profession.

The pressures
The GMC’s policy statement *Revalidating doctors* appeared 7 months after the state’s *Supporting doctors, protecting patients*. Both policies aimed at the governance of medical performance through the functions of standard setting, monitoring and intervention. The pressures that gave rise to this coincidence of policy formation took the form of general ideological shifts mobilised into political demands by the trigger of specific high profile events with sustained media appeal.

Ideological pressure on the established policy community began with the rise of the New Right in British politics and its direct challenge to the NHS’s traditional view of medical dominance in the doctor-patient relationship. In the mid-1980s, New Right intellectuals of the Conservative Party argued that market principles were as equally well suited to the provision of health care as they were to other areas of social policy [14, 15]. Their critique of the NHS suggested that bureaucratic inertia and professional dominance had produced a service unresponsive to the needs of the health care consumer. To correct this, they maintained, what was required was a devolution of money and power to the consumer, greater patient choice of health care provider, and a corresponding diminution of the power of both doctors and managers as competition becomes a reality. However, so long as the NHS remained the sacred and inviolable institution of the welfare state (the ‘jewel in the crown’), the translation of the New Right’s market principles into policy could not escape engagement with a profession and a bureaucracy to whom direct patient power was an alien concept. What was less alien was the creation of a new form of agency relationship between the patient, on the one hand, and the NHS bureaucracy and the medical profession, on
the other. Thus *Working for patients*, the 1989 White Paper which launched the ‘internal market’ as it was known, established purchasing agencies to identify patient needs and commission the health care services to meet those needs through contracts with providers [16].

However, by separating the customer role of payee (DHA, FHSA and GP Fundholder) from the consumer role of service recipient (patient), the new agency relationships simply created a novel form of patient dependency organised at the level of populations rather individual patients and doctors. Patients were not given an organisational base or policy networks in the NHS, remained outside the NHS power structures and policy community, but new ways were invented to look after their interests.

Although the consumerist ambitions of the New Right were duly subordinated to professional and bureaucratic interest, they resonated strongly with an emergent ideological theme concerning the need for the NHS to be more open and accountable to citizens. Part of a broader critique of the ‘democratic deficit’ in government and the rise of ‘the new magistracy’ in public service management, this theme emphasises the inadequacies of representative democracy, the importance of continuing citizen participation in the accountability structures of the welfare state, and links between participation and institutional legitimacy [17, 18]. Thus, for example, the Association of Community Health Councils for England and Wales argued that ‘the principal route in a democracy to close this kind of trust gap between the public and the institution [the NHS] is to promote its accountability and thereby secure its legitimacy’. It continued, ‘the more accountable the NHS, the more the public’s sense of its ownership and the more it is legitimate’ [19].

Although rooted in the quite different value positions of the market and democracy, the themes of consumerism and democratic citizen involvement both act to promote the significance of the patient as a player in the politics of the NHS and, *ipso facto*, constitute an ideological force against the traditional dominance of doctors in the policy community. However, the translation of general ideological shifts into a power advantage for particular groups is dependent on policy networks capable of exploiting the new values combining with particular issues to create what Kingdon calls ‘the
policy window’, where an opportunity occurs allowing problem, policy and political streams to be brought together [20].

On 29th May 1998 the General Medical Council (GMC) ruled that two surgeons from Bristol Royal Infirmary were guilty of continuing to operate on children with heart defects when they knew their death rates were unacceptably high. In addition, a doctor manager was found guilty of failing to stop the operations after he had been alerted to the high mortality. Accompanied by intense media interest, these decisions sent what the British Medical Journal described as ‘nothing short of an earthquake through British medicine’ commenting with some foresight that ‘the reverberations are likely to be felt for years’ [21]. Public trust in doctors would, it seemed, never be the same again. All had changed, ‘changed utterly’ [22]. In the following month, faced with an unprecedented degree of public concern over the issue, the government announced that a formal inquiry, armed with a wide-ranging brief and considerable investigative resources, would be conducted into the management of complex paediatric heart surgery at the Bristol Royal Infirmary trust and its predecessor between 1984 and 1995. The policy window had opened. Other events were to ensure that it did not close.

To the media, the attractions of the Bristol Inquiry were many. It was lavishly resourced (£14 million over three years), there was no easy answer to the questions it posed, its subject was children and therefore emotive, its chair was Sir Ian Kennedy (not a close friend of the medical profession), it was surrounded by local parental action groups, and, above all, it could be linked to other ‘dangerous doctor’ stories - of which there were now a plentiful supply. Amid the plethora of cases of inadequate medical performance illuminated by legal action, GMC investigations, local Trust inquiries and independent inquiries in the period following the Bristol revelations, two stand out as having particular significance for public trust in the profession: the Royal Liverpool Children’s Hospital Trust, Alder Hey and the GP, Dr Harold Shipman.

In September 1999, following the early findings of the Bristol Inquiry that parents had not given their properly informed consent for the hospital’s retention of their children’s organs, parents of children treated at Alder Hey Hospital initiated a series of actions which resulted, firstly, in a CMO investigation into the national situation
regarding the retention of organs, body parts and tissues at post-mortem examinations and, secondly, in an inquiry chaired by Mr Michael Redfern QC into what had happened at Alder Hey itself [23]. The Redfern Inquiry revealed that between 1988 and 1995 the pathologist at Alder Hey, Professor van Velzen, had removed the hearts, brains and other internal organs from all the 850 children on whom he had conducted a post-mortem, ostensibly for research purposes, without the consent of their parents. But its significance lies not only in its contribution to the pressure for policy change, but also in what it tells us about the changing relationship between civil society and medicine. Behind the issue of organ retention is an ideological collision between the established practice and culture of the medical profession as enshrined in dimly perceived laws and the emergent expectations of consumers and citizens founded on new conceptions of health care rights and the ownership of the body.

In 2000, the CMO’s national census of organs and tissues held by pathology services in England revealed the retention for research and teaching purposes of approximately 105,000 organs, body parts, stillbirths and fetuses of which the relatives concerned were largely unaware (p. 22) [24]. The experience of parents at Bristol and Alder Hey was therefore not unique: it was established medical practice for children (and adults) to be interred having had their organs removed but with the relatives believing they had been buried intact. Propelled by the media, what the Bristol and Alder Hey Inquiries did was to transfer this customary activity from the private medical sphere to the public sphere where the high profile politicisation of pathology duly took place. As politicisation occurred, so it threw into sharp relief the political role of the law in sustaining a particular definition of the patient-doctor relationship.

The law in this field reflects and supports the permissive and pervasive nature of traditional medical authority. It may be, as the CMO’s report stimulated by the Bristol and Alder Hey events observed, that ‘the law in this area is old-fashioned, ambiguous and tilted towards marginalising families rather than ensuring that they are equal partners in the decision making process’ (p. 6) [24]. But, equally, it can be said that pre-Bristol the law was very much in line with medical culture. Commenting on the Pathology Department at Bristol Royal Infirmary and its continued involvement in the removal and retention of human material without the real awareness of parents, the interim report of the Bristol Inquiry stated:
We may regret that those standards were the product of a small group of professionals talking to themselves. We may agree that they reflected a degree of professional arrogance. We may lament that they displayed a lack of interest in, or paternalism towards, the views and feelings of parents. But that was how things were. That was the culture of the times. [25].

As the intensity of the exchanges between the Bristol and Alder Hey lobby groups and NHS management indicate, this was not a culture shared by many of the parents involved. For health consumers such as these, consent really did mean ‘informed consent’ and not the ‘lack of objection’ definition enshrined in the Human Tissue Act 1961. Ideological conflict had moved from the latent to the manifest.

Cultural dissonance between patients and doctors was now a force for policy change and public trust in the medical profession a key political issue. So much so that for the politicians it was no longer a question of their taking advantage of a policy window on the reform of medical self-regulation but rather one of attempting to restrict the size of the window for which they would be held to account. They were in danger of losing control of a political dynamic with its own in-built momentum. The policy agenda was large and growing. In his Commons statement responding to Alder Hey, Milburn noted that the clash between modern patient expectations and traditional clinical practice ‘will require changes in practice and changes in policy. It will require changes in medical education….it will also require changes to the law’ [26].

Amid the almost daily reportings of doctors failing their patients at this time, one other event in particular acted to sustain the political pressure for reform. On 31st January 2000 Dr Harold Shipman, a general practitioner, received 15 life sentences for murdering 15 of his middle aged and elderly women patients by lethal injections of diamorphine. Subsequently the first report by the Shipman Inquiry established that the GP had in fact killed 215 of his patients [27]. The Shipman trial reinforced the impression in the public mind that when it came to the control and dispersement of the human body at and after the point of death, doctors enjoyed a distinct social advantage. Shipman was able illicitly to stockpile large quantities of controlled drugs, kill his patients, avoid a referral to a coroner for a post-mortem in all but a very few cases, and arrange the cremation of his victims in the majority of cases, all
undetected. As with Bristol and Alder Hey, the Shipman case illustrated with brutal clarity the large areas of discretion afforded to doctors by the public’s trust in them as self-governing professionals. Moreover it is, as the Inquiry has demonstrated, a discretion woven in the fabric of the procedures for death and cremation certification which assume and are dependent upon the integrity of the medical professional using them [28].

The policy process and institutional context

Although the pressures from Alder Hey and Shipman broadened the range of policy demands to include not just medical performance but also the storage of human tissue, control of drugs, and cremation procedures, it was medical performance that retained the lion’s share of the media’s attention. Both state and profession were under pressure to show how their initial policy statements on clinical governance and revalidation would be translated into reality to ensure the protection of patients. In responding to this pressure, the two sides drew on quite different institutional contexts and cultures that only succeeded in reinforcing the separation of their policy proposals. This then resulted in a policy endgame where the question has become one of who will dominate the necessary engagement between the two policy streams.

State

Sir Donald Irvine, then President of the GMC, observed in 1999 that ‘the outstanding question is how the government’s plans for clinical governance and the profession’s arrangements for self-regulation are to be aligned and ‘docked’ together to give the best results for patients’ (p. 1175) [3]. However, there was no precedent for joint policy formation on the governance of medical performance. For the state, the preferred policy approach was the creation of national regulatory agencies in response to the political exigencies of the moment: agencies that could be given a high profile, if short term, role in the protection of the public. Although at the beginning this process was informed by a strategic view of the state’s eventual destination (greater control over medicine’s self-regulatory territory), this was rapidly undermined both by the scale of the political demands from public and press and by the reluctance, or inability, of the medical profession to adapt its policy developments to the diverse needs of the new agencies. The National Institute for Clinical Excellence (NICE) was
the first to be established (as a Special Health Authority) in March 1999. Its functions were, firstly, to appraise all new technologies for their clinical and cost effectiveness and advise whether they should be in routine use in the NHS; secondly, to disseminate clinical guidelines based on a clear scrutiny of the scientific literature; and thirdly to develop and promote clinical audit. It was made very clear in the course of government consultation that the values governing the NICE’s appraisal activities would be quite different from those which have traditionally informed the profession’s evaluation of research and the dissemination of its views through, for example, clinical guidelines. The NICE view was that whereas

Clinical guidelines are a comprehensive set of best practice guidance relating to the management of all aspects of a particular condition; the appraisal process will be focussed on the value for money of a particular intervention. [5], emphasis added.

The message was that judgements about the utility of the products of medical research were no longer the sole province of clinicians.

Whilst the NICE enabled the state to lay claim to some of the regulatory territory of clinical standard setting, the Commission for Health Improvement (CHI - launched in April 2000, also as a Special Health Authority) was designed to provide the state with an evaluative regulatory function through its provision of ‘effective systems for monitoring delivery of quality standards’ (p. 6) [5]. This was to be achieved through a rolling programme of clinical governance reviews of Trusts covering ‘the organisation’s systems and processes for monitoring and improving services, including patient and public involvement, risk management, clinical audit, clinical effectiveness programmes, staffing and staff management, education, training and continuing personal and professional development, use of information to support clinical governance and health care delivery’ [29]. If the methodology of the review programme initially constituted what Day and Klein acerbically describe as ‘as set of rather vacuous categories waiting to be filled’ then that is probably a reflection of the fact that the regulatory ambition of the state had at this point completely outstripped the CHI’s capacity to deliver (p.27) [30], [31]. But despite the implausibility of the Commission’s approach, the political dynamic continued to drive it forward, so much
so that in the first two years of its existence it became the fastest growing institution in the NHS with its budget doubling from £12 million in 2000-01 to £25 million in 2002-03 and its staffing numbers increasing from 180 to 300 (p.26) [30].

In part this growth has been stimulated not just by the logistical needs of the invasion of medical territory, but also by the need to turn the large increase in NHS spending announced in 2002 (aiming at achieving the target of 9.4 per cent of GDP by 2008) into tangible political profit. Thus CHI was to expand its regulatory functions to monitor the use of this large investment. The government’s intention was that the Commission would then have the capacity to play ‘the key role…in explaining to the public how NHS resources have been deployed and the impact they have had in improving services, raising standards and improving the health of the nation’ – in other words, maximising the political profit from this investment [32]. To this end, the Commission evolved first into the Commission for Healthcare Audit and Inspection (CHAI) and more latterly into the Health Commission with the brief to ‘inspect’, not simply ‘review’ clinical governance (a significant change in nomenclature), be responsible for the ‘star’ system of assessing Trusts, take on the regulation of the private sector from the National Care Standards Commission (NCSC) and produce an annual report on the state of the NHS [33]. However, CHI had no capacity for direct intervention but was reliant on the Trusts themselves, the Modernisation Agency, the regional offices of the NHSE - then subsequently the Strategic Health Authorities (SHAs) - and, ultimately, the Secretary of State.

In terms of the state-profession relationship, the creation of CHAI signalled the policy intention of the state to rationalise and strengthen its hitherto disorganised probes into the territory of medical regulation. But to achieve that coordination of policy, two other agencies established in the flurry of state actions in the wake of the Bristol, Alder Hey and related events needed to be incorporated into a common structure: the National Clinical Assessment Authority (NCAA – April 2001) and the National Patients Safety Agency (NPSA – July 2001). Whereas CHI was designed to deal with the quality of the systems that impact on the performance of doctors, the objective of the NCAA was to identify an individual problem before it ‘becomes a national scandal or a disaster’. To that end, the Authority would
operate a new performance assessment and support service to which a doctor can be rapidly referred, where the concern about their practice will be promptly assessed, and an appropriate system devised. It will see an end to lengthy, expensive suspensions, multiple investigations of the same problem, variable local approaches and delays in actions to protect patients. [34].

However, a subsequent statement by the NCAA itself is less ambitious and more cautious, recognises the constraints under which it must operate, and seeks to contain ‘unrealistic expectations that the NCAA will resolve all patient and professional concerns about doctors in difficulty’. It continues: ‘We need to be clear that we are a service that can and will assist, but the responsibility still lies with the Health Authority or Trust, or with the GMC.’ [35]. So the NCAA can be seen as an enabling agency, which supports the regulatory process but cannot itself initiate a standard setting, monitoring or intervention function.

In contrast to this, the NPSA falls squarely within the monitoring category of regulation. Its genesis and rationale are described in An organisation with a memory which takes a systems approach to the analysis of adverse events, draws on the experience of other industrial sectors such as aviation, and places the responsibility for adverse events with an organisation’s culture, reporting and learning systems rather than with the individual clinician [36]. Having detailed the many and variable ways in which information about adverse events in the Health Service is gathered, compiled and not integrated (e.g. the ‘haphazard’ reporting of incidents in the NHS, adverse reactions to drugs by spontaneous reporting by doctors to the Medicines Control Agency (MCA), complaints, and NHS and public inquiries) the report concludes that ‘even where there is good evidence from high quality systems such as the Confidential Inquiries, the evidence is that implementation of lessons and recommendations is often a very slow process’ (para. 4.59) [36]. Such faintheartedness is not for the NPSA itself, established to coordinate the efforts of the NHS to report and learn from adverse events. Welcoming the Kennedy report on the Bristol Inquiry, its chair, Professor Rory Shaw, said: ‘The Agency has been created to revolutionise patient safety in the NHS in the wake of tragic events such as those at the Bristol Royal Infirmary. We will do this by collecting information about problems, learning from them and putting into place mechanisms which actually do
save lives and prevent adverse events happening in the future.’ [37]. Whether it was politically wise to be quite so ambitious so soon remains to be seen.

Nonetheless, it was an understandable tactic for the NPSA to adopt. The state’s creation of national agencies as a visible policy response to media and public pressure occurred in an *ad hoc* and unsystematic manner and there is, for some, an incentive to compete for the occupation of regulatory territory. The NCAA, however, takes a different line. Diplomatically reflecting on its own position, the NCAA saw itself as ‘a central part of a complex jigsaw of changes to the quality framework of professional practice in the NHS. Many of these changes are not yet complete and depend on each other for their success in achieving the quality improvements.’ (para 6.2.1) [35]. In the absence of an accountability framework which binds and defines the state’s various regulatory inventions one to another, and also relates them to the existing body of NHS procedures, the agencies were obliged to negotiate ‘Memoranda of Understandings’ between them as the means for dividing up the regulatory territory [38]. Subsequent organisational changes have brought certain parts of the jigsaw together (eg the NCAA has been absorbed into the NPSA and the Health Commission has developed its monitoring function), but how the whole edifice engages with the line management system of the NHS to protect patients remains unclear.

*Profession*

While the state succumbed to the temptation to create new bureaucratic means of policy implementation with little regard for how they would be integrated with existing NHS management procedures (such as for complaints and disciplinary action), the profession was faced with a range of institutions (GMC, Royal Colleges, specialist associations) whose potential contribution to revalidation could not be ignored. It needed a vehicle for the introduction of revalidation that would allow the different medical interests to make their own contribution and so preserve their territory within the new policy.

The GMC’s *Revalidating doctors* policy proposal in 2000 had included a detailed consideration of how appraisal might contribute to revalidation (p. 15-19) [13]. That view re-emerges in a joint approach to appraisal and revalidation initiated by the Department of Health and the GMC in April 2002 – described as ‘an historic
collaboration’ – and facilitated through a joint website for doctors [39]. In line with the GMC’s original proposal, the basic information structure of both appraisal and revalidation was to be based on the same seven headings set out in the GMC guidance Good Medical Practice [11]. By this point, the Royal Colleges and specialist associations were well advanced in producing their specialist versions of that guidance and were establishing their claims to governance territory in terms of not only standard setting but also the monitoring and evaluation functions and, in some cases, the intervention function. For example, the Royal College of Obstetricians and Gynaecologists (RCOG) stated that the ‘GMC has overall responsibility for defining the revalidation process but not the mechanisms underpinning it’. Furthermore that the RCOG is responsible for:

- helping the GMC to define the process in relation to our specialty
- benchmarking uniform standards across the country
- checking, by routine visits and random checks, that the procedures are occurring
- responding, with the help of senior Fellows, if a trust has concerns about an individual. [40]

The investment of more time and energy in standard setting meant that the Colleges were in a strong position to influence, if not take over, the state’s activities in this governance arena. As we saw earlier, the National Institute for Clinical Excellence (NICE) was established as the state’s chosen vehicle in this field. It rapidly discovered that medical expertise is a scarce political resource which the profession naturally employs as a bargaining counter in its dealings with the state. The practical outcome of this power imbalance has been that NICE has commissioned standard setting development work from the Colleges. Thus the Royal College of Physicians, for example, set up the National Collaborating Centre for Chronic Conditions (NCC-CC) in April 2001 – one of six NCCs funded by NICE to produce national guidelines and develop audit. What we have, then, is the state funding of development activities by the profession which, via revalidation, could be geared to the needs of medicine’s new, improved self-regulatory apparatus.
The impetus of revalidation also produced adaptations in the Colleges’ approach to continuing medical education (CME) or, to use a more recent terminology, continuing professional development (CPD). As Clair du Boulay has observed, whereas previously the CME approach focused on the updating of medical knowledge by the individual doctor, ‘the changing political climate and need to be more accountable mean that doctors now have to demonstrate that they are developing professionally and that their activities are educationally and cost effective and improve their practice’ [41]. As a result, Colleges have an enhanced role to play because it is their responsibility to ensure the linkage between the professional needs of a doctor, the CPD available, and the process of revalidation. From being an esoteric activity of concern primarily to the individual doctor, CPD acquired through revalidation a political significance which requires that it be managed as part of a College’s maintenance of its regulatory territory. Not taking a proactive stance on CPD would mean that a College, by default, ceded that territory, or allowed the possibility of cession, to the NHS’s managerial line of accountability – a politically unacceptable option.

Assuming that Colleges use CPD as the vehicle for extending their monitoring and evaluation of their members’ and fellows’ activities, there then arises the governance issue of intervention. Where the evaluation shows poor performance, what steps should a College take and what, if any, should be the link to an individual’s College accreditation? Alternatively, should they leave the intervention function to the revalidation procedure? In 2000 the GMC did not appear to see a conflict of interest between itself and the Colleges with regard to this governance function. Reflecting on the contribution of the Colleges to revalidation, Sir Donald Irvine, then President of the GMC, suggested a possible division of intervention labour when he wrote:

But the real challenge and opportunity for the colleges in future lies in the further enhancement of doctors’ professionalism through the meaning of membership and fellowship of the colleges themselves. With GMC relicensure providing the statutory safety net which will deal with poorly performing or wayward doctors, the colleges have an unrestricted opportunity to show that memberships and fellowships are contemporary statements of
good practice. ....It seems likely that those achieving such recognition would have it accepted for the purpose of revalidation. [42].

He continued, ‘It is through this kind of development that the royal colleges should continue to be the dynamic growing point of professionalism in medicine, and the ultimate custodians of our basic values and standards’ [42].

It was always going to be a challenge for the alliance of GMC, 13 Faculties and Royal Colleges and numerous specialist associations to overcome their historic institutional differences and forge a common approach to the implementation of the revalidation policy. Despite the obvious advantages of defeating the state on its own chosen territory of clinical governance, in April 2003 the divisions in the profession became manifest when the GMC announced that it had abandoned the idea of evaluation of a doctor’s fitness to practise by a local revalidation group with lay representation. Instead, under pressure from the Royal Colleges and BMA, it proposed the revalidation, without further scrutiny, of all doctors who had successfully completed five appraisals [43]. This dilution of the original policy, particularly the governance principle of assessment against clear standards, politically exposed the profession and provoked the Shipman Inquiry into observing that revalidation has been ‘seriously weakened’ ‘for reasons of expediency’ and into demanding a review not only of the revalidation policy but of the GMC itself[44, 45]. In February 2005, the revalidation policy due to be implemented two months later in the following April was suspended and the review by the CMO is in progress. As Rosemary Stevens observed nearly four decades ago, ‘many of the problems besetting the English professional associations of medicine have been not of authority in relationship to the government but of their own interrelationships’ [45].

Conclusions
With perhaps unconscious irony, the CMO’s review of medical revalidation was launched by a consultation subtitled A call for ideas that aims to ‘gather views of what the review should cover’ [47]. In other words, after seven years of intense policy development on revalidation no final policy outcome has been achieved. Instead, a fresh agenda setting exercise has been initiated by the state that deals with
basic issues such as the purpose, structures and processes of the revalidation policy. Intriguingly, the consultation document does not mention the government’s own clinical governance policy but treats medicine’s policy making process as a distinct and separate realm in which the state has decided to intervene. It is as though the state has recognised that the isolation of the profession’s policy process is legitimate, though inadequate.

No doubt influenced by the extent of its current political exposure, the GMC is equally convinced that the two policy streams of revalidation and clinical governance need to be brought together. In its response to the CMO’s Call for ideas, the Council is at pains to emphasise that its own contribution ‘cannot happen effectively in isolation from other parts of the regulatory framework’. It points out ‘the need for joined up regulation’ and the importance of ‘making connections’ between the professional procedures of revalidation and the clinical governance arrangements of the NHS employers (para 43-5) [48]. Meanwhile, seven years of separate policy development on clinical governance have produced an elaborate system of organisational monitoring overseen by the Health Commission through its clinical governance review process [49]. Yet the generality of the policy means that at the level of the individual trust the way in which clinical governance impacts on medical performance is indirect and may vary widely. It focuses on the level of the systems that can contribute to the high quality clinical environment rather than the level of the individual medical professional.

The continuing separation of the policy processes of profession and state are a tribute to the stability of their institutions, the paucity of their overlapping policy networks, and the competitive and survival instincts of their politicians so amply stimulated by the political pressures to which they are subject. This combination of factors has produced a path dependency in their twin streams of policy formation that militates against cooperation and integration [50]. Politics it has to be remembered is about the preservation and extension of power, both internally and externally, not the efficient construction and delivery of policy. For the profession, the possible gains of assuming control of parts of the state’s medical governance territory through a standards based revalidation policy were eventually opposed by the logic of its internal alliances and divisions, though the struggle for control of its internal policy
agenda continues. For the state, the difficulties of gaining access to the standard setting knowledge necessary for the governance of medical performance led to a retreat into the familiar territory of bureaucratic system control. There is no reason why this situation should alter.

References


[18] Stuart and Stoker


