The performance of doctors. II: Maintaining good practice, protecting patients from poor performance

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See editorial by Scally

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The public now seeks assurances that doctors remain capable and safe throughout their practising lives. For the profession this means refocusing self regulation on fully established doctors.[1] For the General Medical Council it means that all doctors on the register working in Britain must maintain an appropriate standard of practice. Where doctors do not, the GMC must ensure that action is taken, either locally or by itself. The first concern is to protect patients. The second is to find out what has gone wrong and to establish the cause. The third, wherever possible, is to help doctors recover their fitness for normal practice.

Summary points

All doctors have a duty to maintain good practice

Patients must be protected from poor practice

Dysfunctional doctors should be helped back to practise wherever appropriate

Openness about doctors' performance is essential to public trust

Practising safely

The principle that doctors should be able to show that they practise safely is unarguable. Unfortunately, discussion of the means tends to be contentious because of the threat of "recertification," implying the regular testing of all career doctors. Yet there must be considerable doubt about whether, in our current state of knowledge, a formal national programme of periodic recertification would achieve the results that its advocates claim. There is no consensus on method, and the benefits would be small when measured against the cost of assessing large numbers of doctors already considered to be performing well. Given these uncertainties, a different approach may be more constructive.

Interests of the public and the profession may best be served by the development and implementation of a coherent, properly paced, and well balanced strategy of quality assured, professional self regulation based on the principle of management by exception.[1] This would allow flexibility through strategies tailored to differing needs and circumstances. Practitioners who were known to be working well would be encouraged to continue, while proper attention would be given to doctors at risk or in difficulty.

Such a strategy would rest on a strengthening of our culture of professionalism.[1] It would be inclusive, involving all doctors and embracing continuing medical education, personal professional development, clinical audit and quality improvement methods.[2] It would have six core components:

- a clear ethical framework and, wherever possible, the use of explicit professional and clinical standards[1];
- effective local professional regulation for maintaining good practice;
- regular publication by the royal colleges and others of data showing doctors' involvement in continuing medical eduction, audit, and other performance related activities;
- sound local arrangements for recognising dysfunctional doctors early and for taking appropriate action;
- well defined criteria and pathways for referral to the GMC when severely dysfunctional doctors cannot or should not be managed locally;
- at all stages, practical help and support so that doctors who get into difficulties can be restored to full practice, wherever possible.

GENERAL MEDICAL COUNCIL

Doctors in teams should assume some collective responsibility for their standards of practice

Maintaining good practice

The universities, royal colleges and professional associations, with the NHS, are already strengthening the continuing professional development of established doctors. Each college is showing what is required for effective practice in its branch of medicine. But there is an underdeveloped area—local self regulation—which needs to be highlighted.

Maintaining good practice

Doctors are most likely to maintain good practice when they work in teams which
- Show leadership
- Have clear values and standards
- Are collectively committed to sustaining and improving quality
- Foster learning through personal and team professional development
- Care for each member
- Have a "no blame" culture
- Are committed to the principle of external review
- Are open about their professionalism

Effective teams use
- Clinical guidelines and operational protocols
- Good systems
- Good data
- Good records
- Focused education and skills training
- Systematic audit of performance with feedback
- Regular, formative peer appraisal
- Critical incident review
- Risk management methods

Local professional self regulation

The term local self regulation embraces the policies, arrangements, and processes used by doctors at their place of work, in their locality, and within their specialties to maintain and raise standards of practice and to tackle dysfunctional practice when it occurs.

The starting point remains the duty of the individual doctor. However, today most doctors work in medical and multiprofessional clinical teams. Most general practitioners belong to medical partnerships and practice teams, and comparable arrangements exist in hospitals. The idea that doctors in teams should assume some collective responsibility for their standards of practice is now taking root. It makes sense to create a mutually supportive environment which helps to maintain the clinical effectiveness, integrity, and good name of the team as a whole, including its individual members (box).[3-5] Everybody benefits.

Teams working in this way are able to document and demonstrate the results of their work, including insights on their performance, so that the outside world can see that their members are functioning well.

This kind of proactive, team based, self regulation needs proper resources. It takes time and effort to do well. NHS trusts, health authorities, and health boards should value and support it as a tangible expression of their commitment to supporting modern professionalism in health care.[1] The achievement of management's aims is critically dependent on the sense of professionalism, and commitment, among doctors and other health professionals.[6]

Handling dysfunctional practice locally

The GMC has said in *Good Medical Practice* that doctors have an ethical responsibility to act where they believe that a colleague's conduct, performance, or health is a threat to patients—if necessary by telling someone from the employing authority or from a regulating body.[7] Doctors who ignore this responsibility place themselves at risk of action by the GMC.

In practice the judgment is never easy,[8] so the GMC is thinking about the best ways of helping doctors faced with this dilemma. Its approach starts with self regulating teams of the kind described above because they tend to have the will, policies, skills, and information necessary to identify, confront, and manage dysfunctional practice when it first appears. Firm but constructive handling at that stage can often limit the damage caused to patients and the colleague in difficulty. If team based attempts at remediation fail to resolve the problem, doctors are less likely to feel guilty about asking for outside help.

Beyond the immediate team are the local hospital and district arrangements for professional regulation. These arrangements range from informal peer networks, for example, through local medical committees in general practice and, in hospitals, peer driven NHS mechanisms such as the "three wise men" procedures designed originally to help manage sick doctors.

A determined effort is being made by the profession and the NHS to formalise and strengthen the local arrangements for managing problem doctors, whether they practise with others or are single handed.[9] The chief medical officer has recently given guidance to NHS chief executives and trust medical directors in England.[10] The GMC is working with the British Association of Medical Managers and the BMA to ensure that doctors in local positions of responsibility become thoroughly familiar with the GMC's procedures. It is ready to provide expert advice in confidence about difficult cases, and the boundary between the GMC and NHS complaints and disciplinary procedures is being clarified.

Within 12 months everyone should know what to do and when; what criteria should prompt colleagues working together to refer for local action; and what criteria should indicate onward referral to the GMC.

The GMC: fitness to practise

Some doctors seriously breach accepted standards of professional conduct and practice. Others become ill without recognising the consequences for their patients. Yet others show evidence of a pattern of poor practice, the causes of which include professional isolation, complacency, arrogance, idleness, and simply losing touch. Some are referred to the GMC by patients or are reported by the courts. But if local professional self regulation is working as intended, other dysfunctional doctors will have been identified by their colleagues and local action taken. Some will be beyond local care, necessitating referral to the GMC.

The Medical (Professional Performance) Act 1995 gives the GMC new powers to investigate a doctor's performance and, where it finds the standard of performance to be seriously deficient, to impose

Examples of serious clinical dysfunction in doctors

Case A—A general practitioner, qualified for 25 years, refused to visit several patients whose histories indicated that visits were necessary. He prescribed erratically, often on the basis of inadequate information; in one case this led to a serious adverse reaction. Case notes, when present, were scanty and often incoherent. Despite two service hearings and counselling by a member of the local medical committee, the pattern of dysfunctional behaviour continued.

Case B—A consultant showed lack of skill carrying out practical procedures. In addition he habitually would not listen to patients or colleagues and would respond aggressively to expressions of concern. Time management was a major problem, with no sense of urgency when responding to requests for help from anxious juniors. Despite local offers of counselling, he refused to accept that there was a problem.

conditions on or to suspend a doctor's registration.[11] From September 1997 the GMC will therefore have at its disposal a range of procedures—conduct, performance, health—for dealing with seriously dysfunctional doctors. Protection of the public is the first priority, coupled with the rehabilitation of the doctor wherever possible.

Under these performance procedures, a doctor's registration may be questioned by repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy. This may include repeated or persistent failure to comply with the GMC's guidance in *Good Medical Practice* (GMC minutes, May 1996).

What will happen?

If one or more complaints suggest a prima facie case of seriously deficient performance, the GMC will trigger an assessment of the doctor's practice. The assessment will be carried out at the doctor's place of work by three assessors, two medical and one lay. The medical assessors will be from the same specialty. The initial appraisal of performance may be extended to cover the doctor's knowledge and skills in more depth. The assessment should give an accurate picture of the doctor's performance; this will form the basis for the GMC's decision about what should be done.

Doctors whose performance is found to be seriously deficient, whether locally or after referral to the GMC, should have every reasonable chance of putting things right through remedial action. Doctors will be able to seek preliminary advice and help through their regional postgraduate dean or regional director of postgraduate general practice education.

Looking ahead

The public and the medical profession share a common interest in showing that doctors provide a good standard of practice and care, and that patients are protected from doctors who are not safe. The GMC's strategy offers a practical way forward. Good documentation at every stage, and openness with the results, will be essential to see what works and where the gaps are. The strategy can be developed and refined in the light of experience and on the basis of evidence. Success in implementing this strengthened professionalism should secure the public's trust and safeguard the independence of the profession.

These papers are based on the George Haliburton Hume, Cohen, and Telford lectures (1996) given in Edinburgh, Newcastle upon Tyne, and Manchester respectively. I thank the friends and colleagues who have commented on them.

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Any questions

The usefulness of electrostimulation in treating incontinence

Electrostimulation is sometimes recommended for urge incontinence or mixed incontinence. How good are its credentials and how practical is it in a general practice setting?

Electrostimulation of the pelvic floor in the management of urinary incontinence can be very effective, particularly as part of general treatment with pelvic floor exercises, bladder training, and the use of drugs to inhibit bladder contractions. A variety of methods have been used including vaginal and rectal devices and perineal stimulation. Away from a general practice setting permanent implanted stimulators on the sacral spinal nerves have been shown to have a very beneficial effect in cases of permanent loss of nervous activity.

Application of these techniques has been particularly useful in stress incontinence of a relatively minor degree. Success rates incontrolling symptoms at a year have been in the 60% to 70% range, provided there is enthusiasm in their use. For urgency of micturition the situation is a little more difficult as this is sometimes related to abnormal bladder muscle activity which in theory should not be helped by improving pelvic floor tone, but it has been shown that there can be a reflex inhibition of this abnormal activity as a result of electrostimulation. Consequently it does have a place in treating urgency incontinence.

There are several studies that have used objective criteria to establish the efficacy of these treatments showing between 60% to 70% improvement in continence and sufficient improvement in many cases so that surgical treatment was unnecessary. As with all such treatments the commitment and enthusiasm of the patient can make a huge difference.

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Health in China

The healthcare market

Therese Hesketh, Wei Xing Zhu

This is the second in a series of five articles on changing aspects of health care in China

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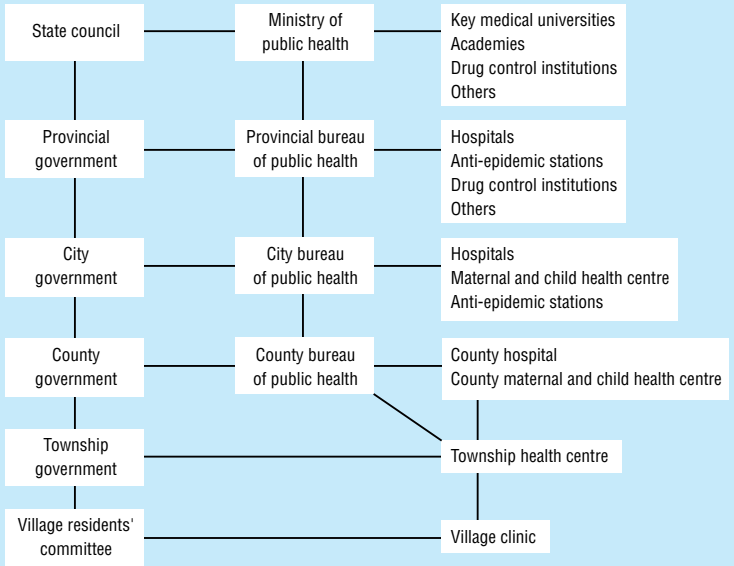
Summary

It is now about 15 years since the introduction of the market into health care in China. This produced fundamental changes in the way that health care is financed and resulted in the disappearance of universal free basic health care. Responsibility for provision of health services has been devolved to the provincial and county governments, and healthcare providers have been given considerable financial independence. A fee for service system has been introduced, and several different payment mechanisms are now in operation. The new financing and pricing structures are responsible for greater inequity of access to services and more inefficient use of resources. These problems are widely acknowledged, and a range of solutions is being developed and tested. Since the introduction of the reforms the measurable health status of the population has not declined, probably as a result of overall improved socioeconomic conditions and a continued emphasis on prevention.

The major changes of the market

The economic reforms of the early 1980s resulted in major changes in the way that health care is financed. (The box shows the structure of agencies that provide health care in China.)

China's healthcare structure



Population at each level varies greatly depending on the region (the eastern coastal region is densely populated and the north and west are sparsely populated)
Province: Average population is 35 million (range 2-120 million)
County: Average population 500 000 (range <100 000 to 1.3 million)
Townships: From 20 000 to 80 000
Villages: From 1000 to 10 000

(1) Central government funding for health care was drastically reduced.[1] It now accounts for less than 1% of total health expenditure, providing some capital grants to hospitals and subsidising preventive services in poorer areas.
(2) Provision of health services became the responsibility of provincial and county governments, who raise their own taxes. But the amount of money available only covers "basic" salaries (which are well below a living wage) and new capital investments, totalling around 20-30% of hospital expenditures.[1] The shortfall has to be found from user fees.
(3) The collapse of the collective agricultural system removed the cooperative medical system, which had provided free health care. Health care is now provided on a fee for service basis.
(4) Hospitals and health centres were given considerable financial independence. They have to generate most of their own income through user fees, but they also have control over the allocation of profits.
(5) A new pricing structure was introduced. This attempts to facilitate equity by providing basic care below cost, but profits can be made from drugs and technology, and this leads to inefficiency.
(6) A variety of methods of payment has developed. These include self payment, private insurance, and work based insurance.

The most dramatic result of the introduction of the market was the disappearance of a system of universal access to free basic health care, which at its best was a model for the developing world. The way the market has been set up has led in turn to two major problems: there is greater inequity in access to services between rich or insured people and poor people, and there is greater inefficiency in the use of the scant resources available because of the anomalous pricing structure.

Inequity and the payment system

For most Chinese people, user fees for health care are out of pocket expenses. In the countryside (where over 70% of the population lives) less than 10% of the population is now covered by the cooperative medical system or a modified form of it.[2] In the cities, state enterprises and large collectively owned companies provide employment based health insurance covering around 45% of the population, but the benefits provided vary enormously.[3] Full reimbursement of medical expenses is becoming a rarity. The high cost of health insurance to employers, by 1990 the equivalent of 8-9% of the payroll,[4] has meant that insured individuals are now paying an increasing percentage of their own costs, and coverage for dependents is exceptional. Furthermore, around a third of state enterprises are running at a loss and are unable to reimburse the costs of care, so the workers are effectively uninsured.[3]

Basically money follows patients, so there are better healthcare facilities in areas where more individuals

are covered by insurance or in the richer agricultural areas where out of pocket costs are more easily met. This is also influenced by the amount of tax revenue raised locally (obviously more in richer areas) and the priority given to health by the local government. This is well illustrated by the ratio of health expenditure per capita between urban and rural areas, which was 3:1 in 1981 and had risen to 5:1 in 1992.[2]

This polarisation has been increased by the new mobility of the peasants: now that the rural infrastructure has improved, wealthier peasants simply bypass the lower level village clinics and township hospitals and present directly at a county or city hospital. This results in underutilisation and diminished income of the lower level services while county and city hospitals are swamped. Some of the large urban hospitals see up to a million outpatients a year; meanwhile staff in township hospitals may see only a handful of patients a week. Occupancy rates of over 90% are the norm at city and provincial hospitals, while county and township hospitals have occupancy rates of 80% and 45% respectively.[1] With so little generated income from user charges, many township hospitals hospital have to rely on a local government subsidy to pay even a living wage to the staff.

But many poor people cannot afford county or city level care. Schemes to improve access for poor people have included a system of phased payment and a "green channel" (treatment first, pay later) for seriously ill patients. But both systems were abused, with some patients avoiding payment altogether, so now almost all hospitals insist on cash prepayments for inpatient care.

Expenditure on health care is now recognised as a major cause of poverty. In one study an average hospital admission was found to cost up to 30% of the total annual household income for poor families.[5] It is estimated that 30% of people who live below the official poverty line became poor because of a serious illness.[6]

Inefficiency and the pricing structure

The pricing structure is specifically designed to facilitate equity of access. The costs of basic hospital services, a consultation, inpatient stay, and simple operations are set below cost. These are laid down in principle by the state finance bureau and then adjusted at a provincial level according to local conditions. This pricing means that most people can afford basic hospital care at least at township level. But hospitals obviously cannot make a profit like this, so there are exceptions to price setting below cost: these are drugs and new technology, and it is these exceptions that lead to inefficiency and poor clinical practice.

The problem of excess drug use

- An infusion of 5% dextrose with some added antibiotics is a common treatment for a cold or a fever. Hospital outpatient departments have infusion rooms where mild complaints are treated with intravenous fluids
- Though many health workers know about the use of oral rehydration solution for diarrhoea, intravenous infusions and antibiotics are still widely used
- A study of appendicectomy patients showed that drug costs for insured patients were twice those of uninsured patients, with no difference in the outcome[7]

Treatments and their cost are prominently displayed at hospital entrance. An obstetric examination costs 0.4 yuan, a caesarean section 80 yuan, a blood test (haemoglobin and white cell count) 4 yuan

Western drugs can be charged at a markup of 15%, Chinese drugs at a markup of 25%[1]; the profits can go directly to the doctor or the institution. Thus massive overuse of drugs is endemic, with everyone from village doctors to provincial hospitals dependent on this income to make profits. The drug bill is estimated to account for 50% of all healthcare costs.[6] Although the desire for drugs is a reflection of the health and illness behaviour of the Chinese, the pricing structure gives practitioners no incentive to change their practice, even when they know they are overprescribing. A few examples of the clinical problems created are shown in the box.

The use of new technology highlights similar problems. Ability to make profits from high technology investigations and treatment provides a natural incentive to acquire equipment for profit. Fees for computed tomography, magnetic resonance imaging, laboratory services (by automated equipment), ultrasonography, intensive care, and renal dialysis can be highly lucrative.[8] Full neonatal intensive care costs a staggering 1000 yuan (£75; $US120) per day at Hangzhou Children's Hospital. This compares with an average monthly income in the area of around 600 yuan per month. Since most work based insurance schemes do not cover children, this kind of care is accessible only to a small minority. Removal of babies by parents who can no longer afford the care is not uncommon.

A study at county level in Jiangxi province showed that the major priority of the health officials was to increase hospital equipment.[9] The more equipment is used, the greater the profit, so investigations such as computed tomography are sometimes carried out for

Full neonatal intensive care costs 1000 yuan (£75) a day—almost twice the average monthly income

Central China, showing places mentioned in this series

relatively trivial conditions for insured and rich patients. More worrying than the overuse of proved technology is the existence of much technology which is unproved or obsolete. There is a "myopia correction machine" in a number of hospitals, which even the clinicians doubt is effective. Patients are charged around 100 yuan per treatment.

Development of a plan for the acquisition of new technology based on risks, costs, and benefits has been recommended by the World Bank,[6] but current funding mechanisms and lack of any central planning for acquisition of equipment provide no motivation to do this.

The positive side

It is important not to lose sight of the positive aspects of the economic reforms. They have been responsible for improvements in socioeconomic conditions, better education, and improvements in nutrition, housing, sanitation, and clean water. These have benefited hundreds of millions of people across the country. There is much else which is good: access to basic services is still better than in many countries. Village level health care, for example, is within the reach of almost everyone. There is a safety net for those living below the poverty line, which entitles them to reimbursement of some healthcare costs. A major programme to increase township hospital utilisation rates through staff upgrading programmes has been introduced nationwide. State subsidies for health facilities and prevention are targeted to the poorest areas. There have been concerns that preventive activities have reduced in some areas because they are less lucrative for health workers than curative care. However, prevention is still high on the political agenda, and spending on this has remained constant in real terms.[1] In fact, the health status indicators of the Chinese population in both rural and urban areas have not worsened since 1981, although there are still marked disparities in health status between the cities and the poor rural areas. Life expectancy has actually improved from 68 years in 1982 to 70 years in 1995.[10]

Health officials acknowledge the problems of inequity and inefficiency and are aware of the paradox: the fact that they seem to be condoning inefficient and inappropriate practice simply to fund the system. The ministry of public health has limited powers to act, because of the way that financing has been devolved to the lower levels. Various efforts are being made at a local level to overcome some of the problems through insurance schemes (box). The plethora of such schemes does show that there is the will to overcome the problems which have been created by the new market. How successful they will be remains to be seen.

New ways of paying for health care

- Parents can pay a fixed amount for a full course of immunisation. If the child acquires any of the vaccine related diseases the parents receive compensation[5]
- In nine cities and over 700 counties there is a government sponsored insurance scheme specifically for women of childbearing age. In Guandong province by 1998 all employers will have to protect their female workers through such insurance[11]
- Women may make a fixed payment for antenatal, intrapartum, and postnatal care (usually until 6 weeks). This also covers any complications that may arise
- In poor counties in Yunnan province a scheme has been introduced whereby the whole population pays 20 fen (about 2p) per month to subsidise delivery in hospital of mothers at high risk

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