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After Bristol: the humbling of the medical profession

How the new system of medical regulation post-Bristol will undermine what really works in medicine - the doctor-patient relationship based on trust.

by **Dr Michael Fitzpatrick**

The report of the inquiry into the children's heart surgery unit at the Bristol Royal Infirmary hospital in the UK - where there was a high rate of child deaths in the 1980s and 90s - has created a villain and a hero.

The villain is Mr James Wisheart, formerly senior heart surgeon at Bristol, who has already been struck off the medical register and now faces demands that his pension, including merit award payments, should be stopped. The hero is Dr Stephen Bolsin, formerly a consultant anaesthetist at Bristol, who has been lionised as the whistleblower over the unit's high death rate and is now a professor in Australia. The media have conferred on him the image of the victimised rebel, who was transported to a penal colony as the price of his principled insubordination.

The response to the Bristol report has been remarkable in its unanimity. It has been welcomed by the government, endorsed by leading medical organisations, and approved by representatives of families whose children underwent surgery in the Bristol unit. The media have broadcast without reservation the report's demand that the 'club culture' of the medical profession must give way to a new culture of regulation by externally imposed standards and performance indicators.

Yet, for any open-minded person who takes the trouble to read the report carefully (12,000 pages, 198 recommendations) and tries to place it in the wider context of medical practice in Britain over the past 20 years, a number of questions arise. Was justice done to the Bristol doctors? Did the inquiry benefit the families? Does the report

accurately identify the failings of the Bristol unit in particular and of the medical profession in general? Do the report's proposals point the way forward for doctors and patients?

My broadly sceptical conclusions are as follows:

- **The fact that the Bristol unit came bottom of the performance league in some areas does not prove the charge of 'gross professional misconduct', for which the doctors were struck off by the General Medical Council in June 1998 and again condemned by the inquiry report.**
- **Though the inquiry appeared to be responsive to the concerns of the affected families, its key proposals followed a reform agenda that has been promoted for many years by key sections of the medical elite and more recently by the New Labour government.**
- **The notion that the medical profession is dominated by a 'club culture' is based on a 50-year old caricature that bears little relation to contemporary practice.**
- **Though it is uncertain whether the proposals for tighter regulation and control of medical practice will be effective in tackling poor performance, they will have the effect of undermining what really works in medicine - the doctor-patient relationship based on trust.**

The Bristol inquiry had elements of a showtrial and a morality play, dramatising the project of reforming the medical profession. The key players in this drama are Professor Ian Kennedy, chair of the Bristol inquiry; Sir Donald Irvine, president of the UK General Medical Council (GMC); and Alan Milburn, the UK's minister of health. The immediate casualties are the Bristol doctors and their patients, particularly the families of all the children who have undergone surgery there over the past two decades.

And in the longer term, the Bristol report is likely to have a damaging effect on medical practice, on relations between doctors and patients, and hence on the wider interests of the public.

What happened at Bristol?

To anybody who has ever tramped the long corridors of an NHS hospital, the report into the children's heart surgery unit at the Bristol Royal Infirmary paints a familiar picture.

James Wisheart, the unit's senior surgeon and also the hospital's medical director, was a typical consultant of the old school. He was conscientious, dedicated and, in the prime of his career, regarded as a pioneering heart surgeon. He was also aloof, autocratic and lacking in managerial skills. Mr Janardan Dhasmana, the former junior surgeon, was mild-mannered and deferential, perhaps lacking in

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confidence and in communication skills. Dr John Roylance, the director of the trust and formerly a radiologist, followed a traditional division of labour, concentrating on managerial tasks while leaving clinical matters to clinicians. Any hospital doctor could name a dozen or more consultants corresponding to these stereotypes.

The ramshackle set-up at Bristol is also embarrassingly familiar. The cardiology and cardio-thoracic surgery departments were in separate buildings, the journey from operating theatre to intensive care unit (ICU) involved a chaotic ride down draughty corridors and in lifts too small to accommodate the accompanying nurses. Though surgeons at Bristol held regular meetings to appraise performance, insufficient resources were devoted to the collection and analysis of the relevant data, making it difficult to compare with other units and hence to identify and confront problems.

There were chronic shortages of staff at every level from cardiologists to theatre and ICU nurses and technicians. There were tensions between anaesthetists and surgeons, and confusions over clinical responsibility in the ICU between intensivists and surgeons. So what else is new?

Bristol's problem was not so much what was distinctive about its child heart surgery unit, but what was happening in similar units around the country in the late 1980s and early 1990s: a dramatic improvement in outcomes. Until cardiac bypass surgery became well established in the 1970s, most babies born with severe congenital heart defects died in infancy. In the mid-1980s, the death rate for open-heart surgery on babies in the first year of life was running at one in four. By the mid-1990s, it had fallen to around 12 percent.

Given the focus on the expertise (or lack of it) among the Bristol surgeons, it is worth noting that the main reasons for the declining mortality were earlier and more accurate diagnosis (by scanning techniques) and improvements in bypass technology and post-operative intensive care, though there were some advances in surgical technique. The distinctive feature at Bristol was that, while this improvement was taking place elsewhere, its death rate remained stuck at around 25 percent:

'We note a failure to progress, rather than necessarily a deterioration in standards. Such a failure is much more difficult to identify and, if identified, far easier at the time to explain away.' (1)

How big was the discrepancy between the outcomes of heart surgery in Bristol and those elsewhere? How big does the discrepancy have to be before it can be considered to be unacceptable, or to justify disciplinary measures? These - the questions at the heart of the Bristol inquiry - remain highly controversial. A comparative study of the performance of the

Bristol unit with that in other specialist centres (commissioned by the inquiry) throws some light on these questions and the difficulties involved in answering them (2).

■ Damned by statistics

Between 1991 and 1995, surgeons at Bristol conducted open-heart surgery on 181 babies under 12 months of age; 43 died. (The requirement to pool figures for a five-year period, necessitated by the relatively small number of operations carried out, already indicates the difficulty of drawing statistically valid conclusions, particularly at an early stage.)

If the death rate in Bristol in this period had been the same as the average of other units, only 24 babies would have died. The 'excess mortality' at Bristol was, therefore, 19. The authors of this study noted that Bristol was not merely bottom of the league of 13 major centres, but was 'an outlier', with outcomes significantly worse than the other units. They considered - and rejected - the explanation favoured by the Bristol surgeons themselves, that they had an unfavourable 'case-mix' as they were operating on babies with more severe problems than those treated elsewhere. They also rejected explanations based on statistical bias or inadequacies in data, though conceding that they could not have done so if the gap between the Bristol death rates and those elsewhere had been of the order of 50 percent rather than 100 percent.

Though these figures are the crux of the case against the Bristol team, their interpretation raises difficult questions. How great a fall below the average should be considered to reveal an unacceptable standard of practice? If all children's heart surgery units are scrupulously ranked according to outcome statistics, the performance of around half will fall below the average. In any unit that falls below the average it is possible to calculate the excess mortality. Even if that is only one, then from the perspective of that baby's parents this is a grievous departure from acceptable standards.

Even with the vast resources of the Bristol inquiry, there was still no hard evidence of surgical negligence

In the parlance of politicians and journalists, 'if one baby dies because of sub-standard surgical performance, then that is one baby too many'. The fact that Bristol came bottom of the league, even by a substantial margin, does not in itself - even in the absence of any other explanation - prove that the local surgeons were incompetent or negligent.

The global figures of the performance of the unit do not allow investigators to apportion blame to individual doctors. In an attempt to discover the responsibility of any particular

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surgeon for the poor outcomes at Bristol, the inquiry subjected a sample of cases to detailed scrutiny. Though they discovered examples of substandard care, they found that this occurred at every stage of the process - from referral and diagnosis to post-operative care - and that responsibility could not be attributed to any particular surgeon.

With the unerring wisdom of hindsight and the vast resources of the Bristol inquiry, it still proved impossible to come up with hard evidence of surgical negligence. It is also unclear how Bristol's performance would compare with that of other units put under the same intense scrutiny.

On this evidence, it might be justifiable to sanction Mr Wisheart as head of the unit and Dr Roylance as head of the hospital trust, but not to single out any other member of the team - such as Mr Dhasmana (the only one of the three not already due for retirement). Whether being struck off the medical register, professional ruin and personal humiliation are appropriate punishments in these circumstances is another matter. Though the report credited all three doctors with a high level of commitment and a long record of service, they were criticised for lacking insight and for their flawed behaviour (notably in relation to teamwork and leadership, but also in their dealing with patients).

Nevertheless their careers culminated, in each case, in being chased down the street outside the GMC by a mob shouting 'murderer' and 'bastard'. The endorsement of the GMC sanctions by the Bristol report, which also purports to promote a 'no-blame' culture in the NHS, is, in the classic understatement offered by an editorial in the *British Medical Journal*, 'ironic' (3).

When Mr Dhasmana observed, in a much-quoted statement, that they were on 'a learning curve' in relation to some surgical procedures, this was an understandable reference to the same curve that had produced the steady improvement in outlook for children with congenital heart disease over the preceding 20 years. Statistician Dr Jan Poleniecki of St George's Hospital in London believes that the statistical evidence used to convict the Bristol surgeons is 'deeply flawed' (4). He notes that though the GMC told them they should have stopped operating, it 'had never issued firm criteria suggesting what was acceptable and what unacceptable': 'Dhasmana has certainly suffered a very severe penalty - because I simply don't see by what criteria he is supposed to have made that decision.'

Dhasmana was struck off by the GMC following a TV outburst by the then health secretary Frank Dobson, who demanded his head. Though this conscientious surgeon, who voluntarily sought further training to improve his technique, has now been readmitted to the medical register, he remains stigmatised by the Bristol case and faces long-term

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unemployment.

- **The culture of the whistleblower**

Should the Bristol surgeons themselves have recognised that their performance was lagging behind that elsewhere and taken steps to deal with the problem?

This is the question that arises from the critical audit figures presented by Dr Bolsin in the early 1990s. Even though Dr Bolsin's figures were based on crude data and contained inaccuracies, most commentators agree that they suggested a significant problem. However, the precise national statistics on the performance of other units that are now available for comparison were not then readily accessible (even now, there is some doubt about whether they are sufficiently robust to make career-affecting judgements about surgeons' performance).

When Dr Bolsin's colleagues blamed their poor outcome figures on an unfavourable case-mix and bad luck there was little he could do to refute them. They did in fact take measures to improve performance, notably recruiting a new surgeon. In early 1994, shortly before operations were suspended in Bristol, Dr Bolsin wrote to the Department of Health indicating that this showed 'a commitment at the highest levels of the Trust to improve and maintain performance'. He concluded that 'there would seem to be little benefit from any further investigation from your end at this stage although this should not be ruled out if words are not converted speedily into actions' (5).

Dr Bolsin's ambivalence notwithstanding, the elevation of the whistleblower was one of the main themes of the Bristol report. Indeed, Dr Bolsin was singled out for praise by Alan Milburn in his statement to parliament. For Sir Donald Irvine, one of the key tasks of the GMC was to overcome 'the pejorative overtones that tend to go with "whistleblowing"' and the way in which it was viewed as 'personal and group disloyalty' (6).

Bristol paediatrician professor Peter Dunn pointed out 'several serious negative outcomes' from the encouragement of this sort of whistleblowing - morale and trust among colleagues had been damaged and public confidence had been undermined: 'worst of all, the breach in confidentiality that resulted has led to the opening of emotional wounds among bereaved and grieving parents' (7).

Another negative outcome of whistleblowing appeared later in 1999. In an anonymous letter to Dr Phil Hammond, in his capacity as *Private Eye* columnist, allegations were made about deficiencies at another children's heart unit, the Royal Brompton Hospital in London. As a result, surgery was suspended while an investigation was conducted - at a cost

of £400,000 - by an independent panel of experts, who subsequently found no substance in the allegations (8).

The panel expressed concern that somebody is 'able to cause so much disruption and damage to a major and worthy medical institution using unsubstantiated allegations and statements surrounded by the cloak of anonymity'. Yet this is the 'culture' which the chair of the Bristol inquiry, the president of the GMC and the minister of health all wish to promote.

The Brompton was lucky. The overreaction there caused waste, but not in the end a miscarriage of justice. We can expect more of both, especially when the government has extended such encouragement to the informers. As Gibbon observed of the informers reporting to the Roman emperor Commodus (prior to his encounter with Russell Crowe), they 'became formidable as soon as they discovered that the emperor was desirous of finding disaffection and treason'. Before long 'suspicion was equivalent to proof; trial to condemnation' (9).

Though the whistleblower may have been satisfied at the steps taken by the Bristol surgeons to improve performance, the GMC and the inquiry were not. They needed to make an example of some doctors to display their commitment to forging a new mode of medical practice and regulation. The doctors responsible for children's heart surgery in Bristol provided convenient scapegoats. The fact that they had prepared detailed outcome statistics - in a high-profile speciality where unfavourable outcomes meant death or serious disability - made them an ideal target.

The persecution of the Bristol doctors was traumatic for them - but the impact on their patients' families was even more devastating

The protracted persecution of the Bristol doctors has undoubtedly been traumatic for them and their families. But the impact on the families of their patients was even more devastating.

- **The abuse of empowerment**

The prominent role of parents was a distinctive feature of the Bristol inquiry - and indeed of the earlier report into the 'retained organs' scandal at Alder Hey, which was, in many ways, closely linked to the Bristol report and contains many parallels with it (10).

The 'empowerment' of patients and the public is one of the main themes in the recommendations of the Bristol report - and the inquiry itself sought to exemplify this approach. In

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fact, the Bristol parents were divided, and increasingly polarised in the course of the inquiry. The Bristol Surgeons' Support Group, led by Michelle Cummings, whose daughter died after surgery by Mr Wisheart, was supportive of the surgeons, believing that they had been scapegoated for the wider failures of the NHS. Stephen Parker, chairperson of the Bristol Heart Children's Action Group, was highly critical of the surgeons.

A few parents have come to play a prominent role, not only in representing the views of the Bristol parents to the media, but also in the new institutions, such as Constructive Dialogue for Clinical Accountability and the National Committee relating to Organ Retention, that have emerged as part of the new framework of regulation of the medical profession.

It is striking that, before the suspension of the Bristol children's heart surgeons in January 1995, there was little evidence of dissatisfaction among parents. The Bristol report notes that of the 1703 complaints received from patients (or carers) by the United Bristol Hospitals Trust between 1984 and 1995, only two related to children's heart surgery (one in 1986 and one in 1993) (11).

However, once the issues arising from the suspension received wider coverage in the media, parental criticisms rapidly gathered momentum. From the outset, then, parental concerns were the result of external intervention in the Bristol unit; the intervention did not take place in response to parental concerns. These concerns had not been previously expressed spontaneously by parents as a result of their personal experiences of the unit.

This point is worth emphasising because of the widespread perception, amplified by the media, that the Bristol inquiry was convened in response to demands from parents and that many of its proposals result from representations made on their behalf to the inquiry. This view has been reinforced by the statements of a small number of self-appointed spokespersons for the affected families. These individuals featured prominently in the press and on TV following the publication of the report, welcoming it, warmly congratulating its chairman and endorsing his numerous proposals.

But - as we shall see - the recommendations of the Bristol report follow closely the programme for reform of the medical profession that has been promulgated over the past 20 years by, among others, Professor Ian Kennedy and Sir Donald Irvine. If some of the Bristol parents felt that the report reflected their concerns, then this indicates the success of these reformers in winning over some of the (previously uncomplaining) parents to their approach. Having won the endorsement of a number of articulate and media-friendly parents for their programme, the inquiry

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team was understandably keen to give them a prominent role in its presentation. This is not to deny that the representatives of the Bristol parents identified with the main themes of the Bristol report. It is merely to indicate that these themes had been drawn up by the leading reformers long before the Bristol inquiry opened.

But, so what? If the parents are happy with the report, does it matter that they merely echo its authors' proposals? There are a number of reasons why it does matter.

As the personal testimonies of numerous parents in the press reveal, every family of every child who passed through the Bristol heart surgery unit in the years covered by the inquiry has been forced to relive the experience. For parents of children who died or who sustained serious adverse consequences, there is a particular burden of grief and guilt. They will never know whether their child was one of the 'excess deaths' or one who would probably have died in the unit at the top of the league table.

Yet the Bristol inquiry has had the effect of turning their suffering into hostility to the surgeons. Their anger has been channelled through the inquiry to provide emotional backing to the campaign for medical reform. Professor Kennedy says that he found many of the parents' accounts 'lacerating', but it is difficult to escape the conclusion that the effect of the Bristol inquisition has been to intensify and prolong the grief of the families. This is the price of the crusade to reform the medical profession.

▪ The campaign for reform

A recurring theme in the discussion about the need for reform of the procedures regulating the medical profession is that this process has been driven by 'public demand'.

TV images of angry protests by the Bristol parents have reinforced the view that doctors' leaders are responding to a popular clamour for new mechanisms of professional control. It is, however, important to recognise that the demonstrations were a response to the end of processes - the GMC and Bristol inquiries - which resulted in sanctions against individual doctors. But the original decisions to suspend these doctors did not take place in response to any public demand. Though health minister Frank Dobson was quick to react to the GMC judgement on the Bristol case, this was merely opportunistic - a populist gesture in response to a high-profile scandal. Nor were the disciplinary measures the outcome of newspaper revelations made by investigative journalists exposing medical incompetence and corruption. The media trailed behind key figures like Sir Donald Irvine and Professor Ian Kennedy, echoing and amplifying their pronouncements.

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A closer look at the unfolding events in the Bristol case reveals how questions about surgical competence became the focus of national controversy. Though the first indication of problems at Bristol appeared in a report in 1989, it was not until January 1995, after the post-operative death of Joshua Loveday, that the trust was obliged to call a halt to further heart surgery on children in Bristol pending further investigation.

The Bristol case certainly attracted a great deal of media attention. But this was virtually entirely in the form of commentary upon a sequence of events initiated and sustained within the medical profession itself. The only significant media exposure prior to January 1995 was in the form of gossip pieces placed in the satirical fortnightly *Private Eye*, by Dr Phil Hammond, then a junior hospital doctor in the Bristol area (12).

In terms of mainstream media coverage, Hammond notes that 'the story was finally broken by BBC Bristol on 6 April 1995, months after both surgeons had already stopped operating' (13). Once the process of investigation was underway, the media - notably a *Dispatches* documentary on Channel 4 in March 1996 and features on the BBC's *Panorama* and *Newsnight* - played an important role in promoting a high level of animosity against the Bristol surgeons. The GMC was keen to show its readiness to take tough action against doctors who were depicted as incompetent. 'I don't think it's the press alone driving this', commented Jeremy Laurence, health editor of the *Independent* newspaper. 'With the Bristol heart surgeons case, it was the GMC that made all the running.' (14).

'British medicine will be transformed by the Bristol case', proclaimed Richard Smith, editor of the *British Medical Journal* in an enthusiastic endorsement of the GMC verdict under the title 'All changed, changed utterly' (15). It was clear that this was as much an expression of his own aspirations as a judgement on the case itself. Smith welcomed the Bristol case because of the impetus it gave to the movement for reform of professional regulation that was already underway, with the support of leading medical authorities. As Smith put it, 'dramas like the Bristol case are powerful levers for change'.

Before the suspension of the children's heart surgeons in 1995, there was little evidence of dissatisfaction among parents

In the course of the 1990s the GMC, long regarded as a highly conservative body made up of the profession's elder statesmen, became a radical force for change. When he was elected president of the GMC in 1995, Donald Irvine proposed a range of reforms including a new framework for revalidation: he told the editor of the *BMJ* that 'we need a

five-year strategy for getting the message over' (16).

It is clear that, for Irvine and the GMC, the Bristol case provided the ideal opportunity to promote the new approach. Before Bristol, numerous worthy policy statements remained the property of the medical elite. Bristol allowed first the GMC and then the public inquiry to add 'drama' to its dry documents and to present the dramatised case for professional reform to a national audience. Doctors might ignore GMC circulars, but they could not ignore the unfolding tragedy of Bristol being played out nightly on TV and daily in the newspapers. The fact that Irvine insisted on personally chairing the GMC hearings on Bristol, despite being asked to stand down by the counsel for the accused doctors because of a perceived prejudice against them, indicated his concern to be closely identified with this high-profile case.

Gynaecologist Wendy Savage made a number of criticisms of the GMC's conduct of the case which echo through the subsequent inquiry. She raised a concern shared widely by doctors in Bristol and beyond:

'The perception among many people, medical and lay, is that these doctors were made scapegoats as a way of satisfying the government that doctors were capable of regulating themselves as a profession. If this perception is correct then a grave miscarriage of justice has occurred and incalculable damage has been done to self-regulation, the medical profession and the parents whose children were patients in Bristol.' (17)

- **'Club culture'**

'A hospital where there was a "club culture"; an imbalance of power, with too much control in the hands of too few individuals.' (18)

The Bristol report describes a number of features of the 'club culture' which it identifies as the root of the problems at the hospital - and indeed of the medical profession as a whole. The first is professional hubris: doctors were arrogant and unaccountable. Too much power was concentrated in too few hands, and both formal and informal mechanisms of control were ineffective.

Secondly, the senior doctors displayed little aptitude for leadership or teamwork. They operated as a clique, creating a perception that other colleagues were 'insiders' or 'outsiders'. Their management style was secretive and punitive, discouraging open and critical discussion.

Finally, in their dealings with patients, they were paternalistic and lacking in respect and candour, sometimes failing to provide accurate prognoses based on previous experience and not fully involving parents in ongoing

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discussions about the care of their children.

Like the description of the buildings and the personalities of the Bristol unit, this account of the operational style of its leading members strikes a chord with anybody familiar with the British hospital system - doctors and patients alike - since the inception of the NHS. But this very familiarity raises a problem. Is it fair that the Bristol doctors should suffer such drastic sanctions because of their adherence to a managerial style that has been commonplace, if not perhaps universal, in the health service over the past half-century? Indeed, the main offence of the Bristol doctors seems to be that they were rather old-fashioned: just as their surgical performance failed to keep up with the advances of the past decade, so did their style of management.

Acknowledging the Bristol doctors' attachment to anachronistic modes of professional practice raises a further question: to what extent is the Bristol report justified in generalising from the local situation to the medical profession as a whole? Failing to recognise the dramatic shifts of the past decade, the Bristol report seems to be fixated on a caricature of the hospital consultant of half a century ago (popularised by James Robertson Justice's portrayal of Sir Lancelot Spratt in the *Doctor in the House* films of the early 1950s). Starting out by tilting at windmills, the report ends up with proposals for reform that fail to deal with the real problems of the medical profession in the new millennium.

Far from being arrogant, today's doctors are diffident and afflicted by insecurity and self-doubt. By contrast with the independent general practitioner, competent on qualification, who symbolised the confidence of the medical profession in the nineteenth century, GPs today are 'never quite competent'. The modern doctor requires continuous ('life-long') formal instruction and regulation, mentoring and monitoring, support and counselling. Junior hospital doctors similarly need careful nurturing and training and protection from the rigours of the old apprenticeship system.

Even consultants must produce personal development plans and display their acquiescence to the new regime. Whereas earlier generations of doctors were ready to take a stand on issues of professional status, today's doctors are more inclined to complain about stress and phone a helpline.

In the cause of slaying the demon of paternalism, the Bristol report seeks to replace the subtleties of the doctor-patient relationship with the imperative of 'informed consent'. But the real problem of contemporary medical practice is that patients tend to be bombarded with too much rather than too little information. As a result, patients sometimes feel that the burden of responsibility for clinical decisions is being transferred from the doctor back to them.

The problem is that, when it comes to submitting to the surgeon's knife, no statistics on outcomes, no league tables, no amount of information and advice, can overcome the gap of knowledge, expertise and experience between doctor and patient. When it comes to the leap of faith required, trust is what counts - and trust is more likely to be undermined than strengthened by the new cult of openness, which may well amount to an evasion of responsibility by doctors rather than a genuine sharing of information.

The barrier to patients - or anybody else - gaining access to information, at least reliable information, in the NHS is not the secretiveness of doctors, but the technological backwardness of the hospital system (a point partly acknowledged in the Bristol report). The disparaged 'club culture' of doctors is crucial to the spirit of trust and cooperation required for the teamwork of modern medical practice. Though it may be true that this spirit of collective commitment and solidarity occasionally shields incompetence or worse, the cost of its destruction would be even higher than that resulting from cases such as Bristol.

The culture of the whistleblower encourages doctors to spy on one another and to inform higher authorities, rather than try to deal with problems through informal mechanisms. The corrosion of trust and mutual sympathy that is likely to result can only demoralise doctors and damage clinical practice, to the detriment of patient care.

■ Control culture

Two key recommendations in the Bristol report were immediately accepted by health secretary Alan Milburn in his parliamentary statement on 18 July 2001.

> **Far from being arrogant, today's doctors are afflicted by insecurity and self-doubt**

He approved the establishment of a new Office for Information on Healthcare Performance to coordinate the collection and publication of data on quality. He also approved a Council for the Regulation of Healthcare Professions, an overarching body supervising the GMC and bodies responsible for nurses and other professions working in the health service. Though these agencies appeared to be an immediate response to Bristol, they are in fact the outcome of a process of reform that has been taking shape within the medical profession over the past 30 years.

In the late 1960s and early 1970s, the emergence of a wide-ranging critique of modern medicine triggered a crisis of confidence within the medical profession itself (19). A number of developments within the world of medicine and wider social and political trends combined to put doctors on the defensive. This crisis provoked a range of responses,

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from within medicine and from outside it. From the 1970s onwards the medical elite became increasingly preoccupied with reassuring itself and others in the efficacy of modern medicine: hence its increasing reliance on statistical techniques to discriminate between different forms of treatment

In 1976, Dr Donald Irvine, then a GP in Northumberland, registered his concern with the quality of general practice. While acknowledging that there had been a 'dramatic improvement' in standards, Irvine was concerned that improvement had led to an increased tension between what he characterised as old-style general practice - traditional, isolated, defensive - and the new-style, progressive model being advanced by the Royal College of General Practitioners.

For Irvine, in tackling this problem, the first priority was better professional education and training. The second priority was 'the need to elaborate standards, measures of outcome'. Thus were the priorities that came to dominate the agenda of the GMC in the 1990s declared 20 years earlier.

In the 1980s and 90s the growing influence of anti-professional and consumerist views contributed to the erosion of trust between patients and doctors, as patients became more assertive and doctors became more resentful. A growing sense of professional insecurity among doctors was expressed in clinical audit, the drive to use the measurement of performance to improve standards, and in the demand for guidelines for clinical practice, substantiated by systematic reviews of the evidence provided by research, particularly clinical trials.

Following the election of the New Labour government in May 1997, the internal aspiration to raise standards converged with the external imperative to modernise the NHS by strengthening managerial control and diminishing professional autonomy. The drive to implement new systems of quality control in the NHS was launched under the banner of 'clinical governance' in the December 1997 white paper *The New NHS*. The two agencies overseeing this process - the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) - opened for business in the course of 1999.

Clinical governance means the extension into the medical world of new mechanisms of regulation through audit that have been developed in business. According to Michael Power, professor of accountancy at the London School of Economics, a perception of a general deterioration in professional confidence and public trust in business and in services, in both private and public sectors, has resulted in a quest for external guarantees of quality and probity.

But audit is not a neutral process: when people subject their work to external monitoring, they find that this process leads inexorably to a reorganisation of their work to comply with the requirements of audit. Though audit is designed to reassure, Power argues that it has ambivalent implications for relations of trust. Where trust is lacking, people hope that it can be restored through audit. But can you trust the auditor?

The audit society tends to create 'an inflationary spiral' of trust in more remote sources of reassurance, or to put it another way, it fosters increasing distrust: 'assumptions of distrust sustaining the audit process may be self-fulfilling as auditees adapt their behaviour strategically in response to the audit process, thereby becoming less trustworthy.' (20)

The net result may be that the quality of service is damaged even though the goals of efficiency, or cost-effectiveness are achieved.

Doctors under attack

In appointing Ian Kennedy, professor of health law, ethics and policy at University College London, to chair the Bristol inquiry, health secretary Alan Milburn signalled his intention to use Bristol to promote the government's plans for reform of the medical profession.

Kennedy's hostility to modern medical practice had been well-known since he devoted his Reith Lectures in 1980 to a veritable onslaught on doctors, subsequently published as *The Unmasking of Medicine* (1981). He endorsed the 'consumerist' challenge to the professional self-regulation of doctors, whom he accused of 'stubborn intransigence' in face of proposals for reform. Now, declared Kennedy, 'consumerism must take another tack':

'A wholly new system of supervision and sanction must be created, with the power to suspend the incompetent or even remove from practice those found to merit it.' (21)

Kennedy's appointment to the chair of the Bristol inquiry provided him with a new opportunity to pursue the campaign he had launched 20 years earlier.

In his interim report on Bristol - the document that initiated the 'retained organs' scandal in May 2000 - Professor Kennedy accused doctors of 'arrogance, born of indifference'. This intemperate outburst inevitably stirred up popular animosities and prejudices over the use of human cadavers for transplantation, research and teaching purposes, and it paved the way for the furore over the Alder Hey report later in the year. As a result, it is now much easier for somebody in Britain to receive the organs of some long-deceased family member than it is to get a viable kidney or liver for

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transplantation.

When he was still a junior health minister, Alan Milburn had threatened 'bad doctors' that they would be 'named and shamed', declaring that they 'should no more expect to be employed by the health service than bad teachers should expect to be employed by the education service' (22).

Ian Kennedy's sentimental approach to problems of children's health is self-indulgent and self-regarding

The following year, the government adopted a higher profile in pursuing the reform of medical practice. In his party conference speech in September 1999, prime minister Tony Blair condemned the 'forces of conservatism' in the health service - specifically referring to the BMA - that were holding back the government's modernising reforms (23). Behind the appearance of a radical, modernising government courageously imposing change on a reactionary medical profession lay a different dynamic. Far from confronting entrenched 'forces of conservatism' in the medical profession, New Labour was able to enter a close alliance with a new medical elite that identified closely with its policies (and indeed helped to form them). By contrast with these powerful 'forces of modernisation' in the health service, voices of opposition were few, isolated and defensive.

In the three years between the GMC's decision to strike off the Bristol doctors and the publication of the inquiry report, a flurry of documents indicated the direction of measures for tougher action against rogue or 'underperforming' doctors, and for closer regulation of the medical profession as a whole. The conviction, in January 2000, of Manchester GP Harold Shipman of the murder of 15 of his patients, could not have come at a better time for the campaign for tougher controls over doctors.

In the past the GMC was mainly concerned with 'bad' doctors. It investigated allegations of malpractice or other misdemeanours, and if such charges were upheld, doctors could be struck off the medical register. But, just as public confidence in the medical profession was little affected by periodic scandals concerning corrupt or lecherous doctors, neither did it depend on the vigorous pursuit of such rogues by the GMC. The prestige of the medical profession had quite different - and until the last decade, quite secure - foundations in the successes of scientific medicine and the vitality of the doctor-patient relationship. While the GMC policed a delinquent fringe of practitioners, the mediocrity of some doctors was tacitly accepted as a price worth paying for the overall benefits of an independent profession.

The key change of the 1990s was that long-tolerated

variations in styles and standards of medical practice were suddenly judged to be 'unacceptable'. This judgement was made, at least in the first instance, not by the public or by the media, but by doctors themselves. One of the ironies of this shift is that, as the case of children cardiac surgery indicates, it took place after a period of dramatic improvements in standards.

Advocates of the new system point to a wider breakdown of trust in relations between doctors and patients and to a loss of public confidence in the medical profession and in its mechanisms of self-regulation. In fact, surveys reveal remarkably high levels of popular respect for the medical profession (24). The greatly exaggerated perception (among doctors) of their loss of prestige reflects the underlying force driving this process forward: the crisis of confidence of the medical profession itself. In invoking public demand for tighter regulation, the leaders of the medical profession have projected their own insecurities into society.

To the extent that there is popular support for measures such as revalidation, it has largely been fostered by leading medical figures in their responses to recent events. The danger of the revalidation proposals is that they will exacerbate the medical profession's loss of confidence rather than alleviating it. The problem is not merely that the drive towards revalidation will lead to the creation of scapegoats and a spate of early retirements, though this is already happening.

There is an even more serious danger that it will degrade the profession as a whole and do further damage to the relationship between doctor and patient.

▪ Tears of rage

Professor Kennedy has been widely quoted as saying that key sections of the Bristol report, notably those on services for children, had been 'written in anger' (25).

Though it is not clear what lies at the root of Kennedy's anger, it long predates his involvement in Bristol; indeed his animus against the medical profession was already evident in his Reith Lectures more than 20 years earlier. In openly declaring his anger towards the Bristol doctors, Kennedy seeks to win recognition for the quality of his personal engagement with the plight of the Bristol families. In fact, he betrays a want of the detachment and objectivity that are essential to the forensic character of a public inquiry.

The judgement of such an engaged inquisitor, and indeed of those who appointed him, are clearly open to question. Kennedy is fully entitled to conduct his crusade to humble the medical profession, but this level of zeal hardly qualifies him for the conduct of a public inquiry. Kennedy's

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sentimental approach to problems of children's health is self-indulgent and self-regarding: while he proclaims his concern for the welfare of children, in effect his own emotional state takes priority.

Nothing could better express the decline in medical professionalism than the virtually universal approval of the Bristol report within the medical profession itself. This reluctance to defend basic principles - such as self-regulation - reflects the current state of demoralisation. It is part of a wider retreat from professional commitments that is also evident in the increase in part-time medical practice, the abandonment of 'out-of-hours' responsibilities, and the culture of fear and loathing of patients that permeates the GP freesheets.

The real losers in the new system of medical regulation that has taken a major leap forward as a result of the Bristol affair are not doctors, but patients.

Dr Michael Fitzpatrick is the author of *MMR and Autism*, Routledge, 2004 (buy this book from Amazon (UK) or Amazon (USA)); and *The Tyranny of Health: Doctors and the Regulation of Lifestyle*, Routledge, 2000 (buy this book from Amazon UK or Amazon USA). He is also a contributor to *Alternative Medicine: Should We Swallow It?* Hodder Murray, 2002 (buy this book from Amazon (UK) or Amazon (USA)).

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(1) Bristol Inquiry, Chapter 20, para 22

(2) *The Lancet*, 21 July 2001

(3) *British Medical Journal*, 28 July 2001

(4) 'Number-crunching medicine', BBC News, 17 July 2001

(5) Bristol Inquiry, Chapter 11, para 72

(6) Irvine, D. (1999) 'The performance of doctors: the new professionalism', *Lancet*; 353: 1174-77

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(7) Dunn, P. M. (1999) 'The affair has had several serious negative outcomes', *BMJ*; 318: 1009

(8) *Daily Telegraph*, 9 September 1999

(9) E Gibbon, *The history of the decline and fall of the Roman Empire*, 1999, p79

(10) The high price of Alder Hey, by Dr Michael Fitzpatrick

(11) Bristol Inquiry, Section 1 Conclusions, Para 5, FN 2

(12) See Hammond, P and Moseley, M (1999) *Trust Me (I'm a Doctor): A Consumer's Guide to How the System Works*, London: Metro

(13) Hammond, P and Moseley, M (1999) *Trust Me (I'm a Doctor): A Consumer's Guide to How the System Works*, London: Metro, p60

(14) Quoted in *BMA* News Review, 13 March 1999

(15) Smith, R. (1998) 'All changed, changed utterly', *BMJ*;316: 1917-18

(16) Smith, R. (1995) 'The future of the GMC: an interview with Donald Irvine, the new president', *BMJ*; 310: 1515-18

(17) Savage, W. (1998) 'GMC made grave error in taking the case on', *BMJ*; 317: 1593

(18) Bristol Inquiry, Summary, para 8

(19) See Fitzpatrick, M. (2001) *The Tyranny of Health: Doctors and the Regulation of Lifestyle*, London: Routledge, Chapter 8. Buy this book from Amazon (UK) or Amazon (USA)

(20) Power, M. (1997) *The Audit Society: Rituals of Verification*, Oxford: Oxford University Press, p136

(21) Kennedy, I (1981) *The Unmasking of Medicine*, London: Allen & Unwin, p139

(22) *The Times* (London), 19 November 1998

(23) *The Times* (London), 29 September 1999

(24) See Fitzpatrick, M. (2001) *The Tyranny of Health: Doctors and the Regulation of Lifestyle*, London: Routledge, p153. Buy this book from Amazon (UK) or Amazon (USA)

(25) *Independent*, 19 July 2001; *Guardian*, 19 July 2001; *BMJ*, 28 July 2001

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