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FACING UP TO PROFESSIONAL ACCOUNTABILITY - PAPER GIVEN AT NATIONAL MEDICAL DIRECTORS MEETING, LONDON, 20 NOVEMBER 1998

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Chief Medical Officer

INTRODUCTION

1. It is my job to wind up today's event with a short talk on the topic of professional accountability.

2. You have opened the day talking about the new quality agenda and how it might be implemented. This is a terrific challenge for all of us - it will require great creativity to get the new integrated approach that everyone wants to see. It will require leadership at all levels in the service. Medical Directors and Directors of Public Health are in the key positions to provide the vision of how this will all work and the leadership to help to deliver it.

3. The climate in which we are addressing these issues has changed in the last 18 months.

4. Firstly, we have seen the end of the internal market. Imagine trying to implement the new quality agenda with organisations sitting in their own fortresses. With purchasers on one side of a fence demanding that certain clinical standards must be met and providers reacting defensively and criticising the lack of insight and the general approach being taken.

5. The days of quality improvement by exhortation have surely gone. We are in a new era of partnership where teamwork will be the route to success and where we must specifically address the rough edges which stop organisations

As far back as 1998 the CMO in England in the wake of major inquiries such as Bristol

joining together to form genuine partnerships.

6. The second way in which the climate has changed poses for us an equally large challenge. The last 18 months has seen a series of service failures which have rocked public confidence in doctors and in the NHS. The Bristol Children's heart surgery affair, the reports in the last few days of the problems in the gynaecology services in South Kent and the earlier criticisms of clinical standards in women's screening programmes. On top of this, you are all aware of cases in our own parts of the country which are currently undergoing investigation. Some of these too will hit the headlines. More cases will be reported as local managers are unwilling to carry some of the responsibilities they have carried in the past - perhaps unwisely - for containing problems and using informal approaches for dealing with them.

7. These serious events mean that the public will never look at the medical profession in the same light again. Nor will the profession look at itself in quite the same way again. They are issues of professional and public accountability.

WHAT THEN IS THIS ACCOUNTABILITY MADE UP OF?

8. What then is this new accountability made up of. You have asked me talk about professional accountability but we must acknowledge that this now has at least three strands:

- firstly, the accountability of the individual professional for the quality of his or her own work

- secondly, the accountability of the professional within an organisation in which he or she works. An accountability , for example to participate in the Clinical Governance programme as it develops

- and, thirdly, their accountability as a member of the senior

staff of the organisation, shared with others for that organisation's performance or more widely for local services.

9. Increasingly, there will be many perspectives seeking to hold doctors to account:

- Patients
- Patient representative organisations
- Employers
- The courts
- Enquiries
- New external bodies
- Politics
- The media

10. So we will see a reshaping of traditional professional autonomy in the light of these developments and changes.

WHAT ARE THE PRESENT PROBLEMS?

11. What are some of the problems of accountability at the moment - and here I will focus for a moment on the poor performance end of the spectrum:

- The public is not reassured that it is fully protected by the present mixture of professional self-regulation and employer procedures,
- serious problems often surface with a disaster when they have been known about in informal networks for years,
- NHS employers are often deterred from taking action because the disciplinary procedures are so daunting and legalistic,
- the emphasis is too greatly on disciplinary solutions to problems which

present late, mechanisms to produce earlier educational solutions are particularly weak,

- there are weak connections at local level between the GMC procedures and the employers procedures so that there is confusion about who does what, when,

- there are huge problems about poorly performing general practitioners, where employers are at "arm's length" because of independent contractor status,

- measures to identify and deal with sick doctors are highly unsatisfactory,

- too many problem doctors are moved on to become someone else's problem rather than dealt with,

- problems which occur are often very complex professional and managerial issues which are difficult to unravel, there is little local expertise to do this,

- when serious problems occur they enter a very protracted phase which can often last months or even years; this leads to loss of public confidence, is often unfair to the doctor concerned and wastes public money.

WHAT WOULD A NEW APPROACH LOOK LIKE?

12. How do we address these issues?

(a) Prevention and early recognition

i) Educational - ensuring that programmes of education and training from medical school, to NHS placements, to Royal College

examinations are all aligned to produce the doctor with the knowledge, skills, attitudes and values which will prevent the small but significant number of "poor products" of the present training system,

ii) Appraisal of performance and competence - strengthen performance appraisal mechanisms which at the moment are done well in some places, patchily in others and not at all in some. Particular components of this part of the strategy are:

- medical undergraduates: better recognition of students whose attitudes and conduct are likely to make them "problem doctors" (this is not done systematically at the moment),

- performance appraisal of consultants: in many Trusts, the Medical Director/Clinical Director axis has started to ensure that all Consultants have annual reviews of their performance and personal development plans (this should be made comprehensive),

- annual assessment of doctors in training: under the new specialist training arrangement all specialist trainees have an annual assessment (the so-called RITA exercise). The present intelligence suggests that this is beginning to work but that there are still examples of trainees who get into difficulties, who are investigated and are found to have "passed their last RITA". Also senior house officers are completely excluded from this group (this new machinery needs to be strengthened and broadened with special attention to training the trainers),

- revalidation by the GMC: the GMC (supported by the

Royal Colleges) is about to pass through its next Council Meeting, proposals to introduce compulsory validation (say every five years) of a doctor's licence to practice; the logistics and cost of this have not been thought through but it is likely to prove irresistible because of its high public profile (the key will be to integrate it with the rest of the strategy).

iii) Enhancing good practice

Notwithstanding the importance of education, training and appraisal to prevention and early recognition of problems of poor practice, all current initiatives to enhance good practice (evidence based medicine, clinical practice guidelines, NICE) will also play an important part,

iv) Clinical governance: the overarching local mechanism

Developing all NHS organisations so that they embrace in full the goals of clinical governance will help to prevent, or recognise early, the types of poor practice which has occurred in the service up to now,

v) Stress reduction and management training

Doctors at all levels have repeatedly pointed to the stressful nature of their work for which they have no outlet or support and the fact that they receive little formal training in organisational and management matters. Action taken to remedy this would play an important part in prevention,

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vi) Better data and surveillance

Information systems need to be developed to provide routine data which will allow poor standards of care to be detected. These hardly exist at present.

b) Resolution of problems

No matter how successful preventive measures are, there will always be problems of poor practice which arise. More importantly, over the next 3-5 years, a larger number of incidents will surface as local services begin to "declare" problems which have been festering. For all the reasons described above, these problems are not well dealt with at the moment.

13. We need a new way of handling which joins together the profession, the educational bodies, the regulatory machinery and the NHS to create an integrated framework of action.

RETURNING TO ACCOUNTABILITY

14. Let me return to look at accountability in a quality context which is the theme of today, we could say that a health professional is accountable on four main areas of quality

- For maintaining high standards
- For failure and its avoidance
- For organisational aspects such as team work, delivering corporate goals and running an accessible service
- For quality improvement

The last of these is probably the most exciting part of a new accountability.

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CONCLUSIONS

15. So the new quality agenda is a positive and forward looking one but there is an expectation that it will deal quickly and effectively with the poor performance end of the spectrum. It is in this way that we will restore public confidence and create some space for the important and long term developmental transformation we need to achieve.