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Physicians Maintaining Good Medical Practice:

Clinical Governance and Self-Regulation

Summary

Physicians have always aimed to maintain standards in their clinical practice and have generally achieved this. There is now a need not only to improve the methods for maintenance of standards but to demonstrate in an open fashion that individual physicians are indeed continuing in competent clinical practice. The key components are: ***1) appraisal; 2) CPD; 3) participation in national audit; 4) regularly updated personal development plan; 5) peer led service review.*** Some of these are achievable immediately while others will require further resources and planning. Several need active College support.

The following can be introduced in the immediate future:

- Annual, thorough two-way job plan review and appraisal of performance with a Clinical or Medical Director. The RCP will give advice on the job plan for all physicians (see Responding to Change, 1996, Working for Patients, Part 1, 1998, and Part 2, 1999)
- The introduction of regular CPD of an interactive nature, based on a personal development plan, with assessment programmes being followed as they develop.
- Involvement in local or national audit of clinical outcome and process with evidence of action resulting if required.
- Introduction of a Royal College of Physicians Standards Adviser for each Trust or group of Trusts to assist in all of the above.
- Piloting of multi-disciplinary peer assessment service reviews of clinical teams.

Other initiatives which are recommended and which will need to be explored and costed include:

- Development of standards in the clinical specialties in conjunction with specialist societies.
- Establishment and introduction of evidence based clinical guidelines of effectiveness and management.
- Development of processes for Continuing Professional Development.
- Identification of poor performance in colleagues.
- Election to and maintenance of the FRCP dependent on the satisfactory fulfillment of all components of clinical governance and self-regulation.
- Provision of audit tool kits.
- Critical incident reporting as a further component of clinical governance.
- Development of programmes for training in assessment, appraisal and educational supervision.
- Development of retraining programmes.

- Special service reviews at request of Trusts and Health Authorities.

Physicians Maintaining Good Medical Practice:

Clinical Governance and Self-Regulation

MAIN DOCUMENT

Self-Regulation has long been a central tenet of medical practice, and developed its legal framework with the first Medical Act of 1858. The responsibility for that self-regulation rested on low-key central mechanisms of the General Medical Council, supported by the ethical responsibilities of individual doctors.

The public and the profession now have expectations of higher standards and less variability of practice and behaviour. Notable examples of this change are the GMC's publications "Good Medical Practice" and "Maintaining Good Medical Practice", and the Government's obligation on Hospital Trusts to establish systems of clinical governance with the first annual reports due by 1 April 2000.

The General Medical Council stresses that to maintain a good standard of professional work it is necessary to achieve the following:-

- clear standards wherever possible
- effective quality assurance, especially in clinical directorates
- sound professional arrangements for dealing with concerns about particular doctors

This analytical approach to individual and team practice has already been encouraged by the Royal College of Physicians with its several initiatives in fostering and producing guidelines and audit materials, as well as its supportive advice for physicians in the publications "Responding to Change" (1996), and "Working for Patients" (1998; 1999). Further change is demanded however; we shall have to demonstrate clearly good, effective practice - not just assert it.

This document outlines the steps the College wishes to take over the next two years to ensure the maintenance of high standards of practice by physicians in England and Wales.

DEFINITION OF CLINICAL GOVERNANCE

Clinical Governance is the acceptance of the responsibility of individual physicians to work in a way which is consistent with the values and strategic objectives of the organisation in which they are employed. Within this there is a responsibility to maintain good medical practice and achieve high standards. The responsibility of the organisation (Trust) is to provide appropriate facilities for medical work and to support the professional development of physicians and clinical teams on a continuous basis.

GENERAL INTRODUCTION

The Royal College of Physicians has always been involved in maintaining standards in clinical practice through many activities: more recently these have included the MRCP examination; educational initiatives; the approving of training posts in hospitals; its representation on Advisory

Appointment Committees, and a considerable number of publications giving leadership in good medical practice. Physicians look to the College for advice about good practice and it is necessary and important for the College to make public pronouncements to highlight the scope of good medical practice and, when necessary, to criticise actions of Government and other organisations which adversely affect standards. Through its committees and administrative structure, both in London and in the regions, it provides advice and support to allow physicians to be aware of the varied needs for their practice of medicine and the maintenance of standards.

The College and its Members and Fellows must now discuss and introduce new ways in which they not only improve the quality of their practice but demonstrate to the public, themselves and their colleagues that they still maintain high standards.

In introducing and encouraging new methods of assessment of clinical practice, and demonstrating maintenance of standards, the College is aware that such assessments threaten extra work on top of already heavy and onerous schedules. Clinical governance and regulation by physicians working with management will however identify inadequacies in facilities for practice. This whole process should be seen as a dual responsibility: of the physician to maintain good standards; of management to provide adequate resources. The College will meanwhile continue to press for the additional consultant staff required to make clinical governance a feasible and useful proposition.

A small percentage of physicians are performing below standard, and thus their patients are at risk. In the past, doctors who have recognised failings of colleagues have not always taken effective action in such situations. Together with the concepts of clinical governance and self-regulation must go a change of attitude and culture, in which colleagues, who are not managing their work adequately, can be helped. Physicians should be able to accept that this is a helpful necessity, not a distasteful recrimination.

ROLE OF AND ACTION BY THE ROYAL COLLEGE OF PHYSICICIANS

1. Standards Committee

A new Committee, reporting to the Clinical Affairs Board, has been established to lead change and to oversee all matters concerning standards of practice, including establishment of explicit standards, their measurement and methods of assessment. An urgent priority will be the publication of "Good Medical Practice for Physicians", based on the GMC's "Good Medical Practice".

2. Specialties

Appropriate standards (and methods of monitoring) will vary between specialties. The College will collaborate with Specialist Societies in developing standards for all 25 specialties represented by the College.

3. Annual Appraisal

This is a key component of Clinical Governance and is a Trust responsibility. It must include an annual review of the Job Plan to ensure that physicians are working appropriately. The College, through its Standards Adviser, will give guidance on the detailed content of the Job Plan. The Appraisal based around the Job Plan is the single most important method of identifying the effectiveness of individual physicians. (see Working for Patients Part 2, 1999)

4. Guidelines and Clinical Audit

The College's Research Unit has been re-modelled and has become the Clinical Effectiveness and Evaluation Unit. In collaboration with the Standards Committee and Specialist Societies, it will continue the work of producing evidence-based guidelines. It will also serve as a clearing house for guidelines relevant to medical specialties. The best objective test of clinical practice standards is appropriate audit, including outcome measures (with proper allowance for case mix and other potential confounding factors). The Clinical Effectiveness and Evaluation Unit will develop the appropriate tools. It will also help to identify reliable outcome data or process measures when outcome data are not available. There will be close collaboration with NICE in all of this work.

Effective clinical audit cannot be carried out without appropriate information technology. Indeed, clinical audit should not be attempted if the basic data are not available in a suitable form and we wish to highlight the inadequate provision of information technology in many hospital Trusts at present. Initially local audits are all that will be possible in many areas, with participation in national audit the ultimate goal when the appropriate IT becomes available.

5. Peer Assessment and Service Accreditation

Assessment of individual practitioners or clinical teams by other clinicians or groups (peer assessment) can be invaluable. Such assessments are costly in resources and manpower particularly when directed against individuals. In addition, subjective value-judgements may be misleading, and if adverse might lead to complaints or even legal action. External peer assessment against explicit standards is time and resource-consuming, both for the visitors and the visited (eg. if it were aimed to peer-assess each specialist unit at 5 year intervals, a Trust with all 25 medical sub-specialties would have one medical visiting team every two months; add to that surgical and other specialties and the prospect is daunting but nonetheless may be essential). Some specialties (such as Thoracic Medicine, Cardiology and Nephrology) have already introduced peer assessment and the College is working closely with other Colleges and Specialty Societies to test different systems of team assessment. We intend to pilot schemes involving multi-disciplinary assessment using explicit criteria to yield measurable outcomes which can serve as comparators with other similar services. Lay representation will be introduced.

Less rigorous assessment might be possible by extending the brief of existing visits related to training. If the teams were asked to make some observations about the adequacy of trainers' clinical practice, involvement in audit and CPD, etc, it might give an early indication of weak practice. This might provide an interim measure whilst resources are identified to enable the introduction of the full system

6. Continuing Professional Development

Central to maintaining and improving standards is the concept of continuing professional development and self-assessment. Most physicians have always kept themselves up to date. Now they are expected to demonstrate their state of knowledge and physicians have accepted the concept of keeping records of their CPD activities. However, filling in a diary of educational activities has limited value. Innovative and interactive CPD programmes are being developed, in which self-assessment will be built-in. These will ultimately link to the College via the Internet giving evidence that self-assessment is being undertaken and providing early warning when results are consistently poor. Such self-assessment may lead to the demonstration of the need to update in certain areas. Adequate funding for CPD must be provided. This funding

cannot be the responsibility of the College although the College's CPD Unit is actively developing such programmes and will publish details separately.

When adequate methods are available, CPD and CPD will become mandatory for all career-grade physicians.

7. Improving Performance

Physicians may become aware that their knowledge or performance in some areas is below standard. It is their professional responsibility to remedy such deficiencies, but they may not easily be able to do so unaided.

Their employer has a responsibility to assist by providing time and resources for whatever educational processes are needed, and the College will always be prepared to give appropriate advice and, if necessary, help with any practical arrangements.

In the occasional instances where a physician's performance is so defective that he/she has to stop practising (by suspension, or by a GMC decision about registration), there is no available method of resourcing the necessary professional rehabilitation. The Standards Committee will seek ways to find methods to support this desirable process and will establish appropriate schemes if funds are provided by the Department of Health or Trusts, as well as constructing appropriate programmes.

8. The College Network

The RCP now has a substantial network of physicians with specific responsibilities for College policy in their own areas, and who are in regular communication with the College. These are:

Regional Adviser }

Deputy Regional Adviser }

CPD Adviser } - for each Deanery

22 Regional Specialty Advisers }

Trust Tutor }

Assistant Trust Tutor } - for each Trust or group of Trusts

Standards Adviser }

The Standards Adviser is a new post designed specifically to assist colleagues in matters pertaining to clinical governance and, importantly, independent of the Trust clinical governance machinery although inevitably in contact with the latter when required. The role of the Standards Adviser is to act as an independent adviser to individual physicians, and the Trust, on all matters affecting clinical governance. The postholder will encourage physicians in their approach to CPD, advise them about job plan preparation and career development as well as advise Trust Chief executives and medical Directors about RCP recommendations on clinical standards, CPD and career development.

9. Election to FRCP

Advancement to FRCP has always been dependent on evidence of a good professional reputation and performance, but this has customarily been obtained by subjective reports from a few senior colleagues. Work will proceed to ensure more direct evidence of adequate performance before admission to Fellowship, such as assessment of CPD and an indication of involvement in clinical audit, e.g. no-one will be elected to the Fellowship if they are not up to date with their CPD. Maintenance of the Fellowship may also become dependent on continued participation in these programmes.

10. Consultant Advisory Appointment Committees

The College representative on AACs has always been relied upon to indicate whether candidates' experience and training were adequate for the post. The selection of such College representatives is being overhauled and instructions are being revised to ensure that this important task is performed well.

11. Service Review

The College has always been willing to respond to requests from Managers, Trust Boards or physicians to send a suitable team to review a service and make recommendations, when it seems that there may be some weakness or failure of service provision. This will continue under the direction of the Clinical Vice-President. The speed of response will be determined by the circumstances, but the College will always try to act quickly for the sake of patient's safety.

LOCAL INITIATIVES

Clinical governance, as currently formulated, is intended to operate at local level, and is a responsibility of the Chief Executive of NHS Trusts. The vast majority of physicians work in the National Health Service - a local Trust hospital - but, of course, the principles formulated in this document apply to those working in other areas such as private hospitals, prisons, hospices, etc. Discussions are indeed underway to introduce similar systems into the private sector.

1. The Job Plan

This should be regarded as a two-way tool. A physician should have a detailed discussion annually about the job plan with the Clinical or Medical Director. This is an opportunity for the Clinical Director (and therefore the Trust) to identify any deficiencies in resources and facilities, as well as an opportunity for the Clinical Director to appraise the work of the physician, raising any points of criticism that may have been made in the course of the past year. Such appraisal of working ability and performance is now the norm in many occupations and should be accepted by physicians as an essential part of their professional life.

For the physician, this should be the opportunity for discussing continuing professional development, whereby plans for a change in working style can be discussed year by year. No longer is it acceptable for all physicians to be appointed to a consultant post and then work to the same pattern for up to 30 years. The opportunity to discuss new methods of practice, changing competencies and developing ambitions of physicians must be regarded as professionally desirable. Not all physicians will wish to alter their job plan, but they should have the opportunity to discuss the possibility of change.

The listed items in the job plan are:

- Ward Rounds
- Clinics
- Procedures (endoscopy, catheters, etc)
- Teaching (undergraduate and postgraduate)
- Continuing Professional Development/CPD
- Audit
- Cover Arrangements and Post-Take Ward Rounds
- Administration
- Managerial Work
- National Work
- Research (in some cases)

It is self-evident, when presenting this list, that to take on all these duties is beyond the ability of a physician within their contracted hours. Unless this annual appraisal of the physician's work is carried out, management will never be under pressure to provide sufficient facilities and personnel to allow the majority of these tasks to be carried out. Indeed, it will become apparent that since an individual physician cannot carry out all these tasks, more physicians will be necessary. So while the physician is openly accepting inspection and assessment of his work, he should demand that there is adequate information technology for audit, good funding for CPD and an allowance of time for teaching, research, learning and managerial duties.

2. Clinical Teams

Physicians in modern medical care are all working in teams, whether they are formally identified or not. Many aspects of governance and assessment are easier to achieve when the team is regarded as the Unit of Medical Work. Quoting the GMC document "Good Medical Practice", "Most doctors today practise in medical and clinical teams. As well as being responsible for their own performance and conduct, they should share the responsibility for the quality of care provided by their team. Medical teams are usually organised around Clinical Directorates in hospitals. Clinical teams include colleagues in other health professions".

The GMC goes on to state that medical and clinical teams must be well-led and managed, and must:

- Have a positive attitude to patients and listen to their wishes and needs.
- Make themselves aware of what patients think about the quality of their services.
- Have a clear understanding of their professional values, standards and purpose.

Team members must be:

- Willing to learn.

- Committed to providing good quality service and effective clinical practice.
- Open and honest about professional performance, both together and separately.

To help maintain quality, clinical teams will normally use:

- An active and supportive approach to the professional development of each member.
- The standards set by a professional organisation.
- Recommended clinical guidelines.
- Detailed performance records.
- Internal and external medical and clinical audit.
- Regular review of individual members' performance.
- Suitable procedures for looking into complaints, and avoiding unnecessary risk.

Mutual respect for team members is essential. Professionals working in teams are skilled, highly qualified and as committed to good patient care as the medical profession and should be respected as such.

Finally, if a team is working well - or is to work well - then any individual in that team is unlikely to be performing badly and, if so, should be identified and discussed. This emphasises the value of assessment of teams rather than just individuals.

3. Identification of Poor Performance

Failure to identify a poorly performing colleague is now regarded as a deficiency which could lead to disciplinary action. The public requires assurance that we have developed effective methods of doing so, and removing such physicians from practice - either temporarily for re-training, or permanently. Having accepted that such a change in culture and behaviour is now necessary, consideration must be given to how it could work sensitively and efficiently.

The Standards Committee will continue the process of giving College advice about dealing with possible or potential poor performance. Concern about possible poor performance should normally be addressed to the Trust's Medical Director, who has a clearly defined responsibility for clinical governance. If a Clinician is uncertain about setting such a formal investigation in train, he/she may prefer first to discuss the matter with the College's Standards Adviser, who will have specific responsibility for advising on RCP recommendations and processes.

4. Critical Incident Reporting

A highly effective method of identifying deficiencies in clinical management has been developed by the Royal College of Surgeons - Confidential Enquiry into Perioperative Death. Such measurements are more easily carried out in the surgical area than in medicine, particularly when referring to chronic conditions. Consideration should be given to a system of critical incident reporting in medical wards, a system which is being carried out in some hospitals. Definition of a critical incident will have to be carefully considered. The possibility of a Confidential Enquiry into deaths of emergency admissions under the age of 50 is under discussion with NICE.

Conclusion

The long established mechanisms for regulating the medical profession are no longer good enough. The public, the profession and the Government all expect a much greater degree of accountability, with less variation in standards of practice and behaviour. It is up to us to demonstrate as clearly as possible, through clinical governance and self-regulation, good and effective practice.

Clinical governance imposes a responsibility on physicians to maintain good medical practice and to strive for the highest standards. At the same time it places a responsibility on the employer to ensure that the appropriate resources and facilities are in place to allow this. For many years the College has been involved in standard setting through a range of activities including the MRCP(UK) examination, the approval of training posts and the publication of guidelines. However the College must now introduce new ways to improve the quality of practice and to demonstrate publicly its commitment to the maintenance of the highest possible standards. The College will do this in two ways: introducing a number of initiatives aimed at encouraging physicians to aspire realistically to the highest standards of clinical practice; persuading the Government and employing Trusts to put in place adequate resources and manpower to allow clinical governance to bring real benefits to patients.

Some of these initiatives can be put in place immediately, while others will inevitably require more time to enable sufficient resources to be identified. What is essential is widespread recognition of the key components of clinical governance; appraisal, CPD, national audit, personal development plans and peer led service review.

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