Perceptions of good medical practice in the NHS: a survey of senior health professionals

Allen Hutchinson, Melanie Williams, Keith Meadows, Rosaline S Barbour, Roy Jones

Abstract

Objectives—To categorise senior health professionals’ experience with poor medical practice in hospitals and in general practice, to describe perceptions which senior NHS staff have of good medical practice, and to describe how problems of poor medical practice are currently managed.

Design—A postal questionnaire survey. The questionnaire sought perceptions of good medical practice, asked participants to characterise deviations from good practice, and to describe experience with managing poor performance at the time of the introduction of the General Medical Council (GMC) performance procedures.

Setting—A range of NHS settings in the UK: hospital trusts, health authorities/boards, local medical committees, community health councils.

Subjects—Senior health professionals involved in the management of medical professional performance.

Main measures—Perceptions of what constitutes good medical practice.

Results—Most respondents considered that persistent problems related to clinical practice (diagnosis, management, and outcome and prescribing) would require local management and, possibly, referral to the GMC performance procedures. Informal mechanisms, including informal discussion, education, training, and work shifting, were the most usual means of handling a doctor whose performance was poor. Many took a less serious view of deficiencies in performance on manner and attitude and communication, although consultation skills rather than technical skills comprised the greatest number of complaints about doctors.

Conclusions—Senior NHS professionals seem reluctant to consider persistently poor consultation skills in the same critical light as they do persistently poor technical practice. These attitudes may need to change with the implementation of clinical governance and updated guidance from the GMC on what constitutes good medical practice.

Keywords: quality improvement; medical practice; poor performance

Problems with quality of care in health services are usually multifactorial, often related to systems inadequacy or failures, commonly the responsibility of many rather than a small group or a single individual. Nevertheless, the significant contribution which a single clinician can make to a system failure, through failing to perform to an adequate standard, lies behind several of the recent policy initiatives on quality improvement in British medicine and which have been concerned with the recognition and management of doctors who do not perform to an adequate standard.

This particular type of quality care problem is acknowledged to be an often complex and difficult process in which the outcomes can be uncertain for both doctors and patients. Nor is it only an issue afflicting doctors and their patients. Most of the other clinical professions in the UK now have regulatory bodies, and these are now all facing the challenge of balancing public and professional needs in the face of poor individual performance.

Rosenthal undertook an extensive qualitative study of the issue of “the incompetent doctor” in the NHS in the early 1990s, in which a case study approach was used to show the types of problems met by senior NHS staff and of the effects on patient care, both in process and outcome dimensions. Prophetically highlighting the impending challenge to professional self-regulation, she found that poorly performing doctors were generally only restrained when a situation became potentially catastrophic. Studying the informal mechanisms for dealing with poor performance of doctors in the NHS (used much more frequently than the formal complaint mechanisms), Rosenthal pointed to the often frustrating and unsatisfactory nature of a quality review, quasiregulatory, process which seemed to have no real sanctions.

Coincidently, Lens and van der Wal examined the problem doctor from an international perspective, bringing together contributors whose work demonstrated that most developed healthcare systems have difficulties in managing doctors whose performance is poor. From his work in managing problems among hospital doctors, Donaldson identified 11 categories of personal problem, behaviour, or aspect of clinical practice which might result in the need for remedial action (box 1). Similar forms or causes of problem practice have been identified in countries such as the Netherlands in specialist practice, and as in

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Poor attitude and disruptive behaviour
- Doubts about clinical judgment and competence
- Ill health
- Extreme workaholic tendencies
- Difficulty with personal behaviour and lifestyle
- Poses a specific health hazard
- Stress
- Lack of commitment to duties
- Dishonesty
- Disorganised practice
- Poor communication

Box 1 Categories requiring remedial action. Adapted from: Donaldson LJ. Doctors With Problems in a Hospital Workforce.

the UK, other countries have begun to put in place regulations to contain poor practice. Not all regulatory mechanisms have proved successful.

The General Medical Council’s role in self regulation
The General Medical Council (GMC) is the UK institution responsible for the registration and regulation of doctors. During recent years it has issued increasingly explicit advice on the nature of good clinical practice, recently updated through Maintaining Good Medical Practice and a further revision of Good Medical Practice publications which are sent to all UK doctors on the GMC register. Doctors are expected to adhere to this guidance, which sets out clear good medical practice criteria for all important aspects of care, together with advice on the management of poor performance and the duties of a doctor when faced with a case of poor performance (box 2).

In particular as a doctor you must:
- Make the care of your patient your first concern
- Treat every patient politely and considerately
- Respect patients’ dignity and privacy
- Listen to patients and respect their views
- Give patients information in a way they can understand
- Respect the rights of patients to be fully involved in decisions about their care
- Keep your professional knowledge and skills up to date
- Recognise the limits of your professional competence
- Be honest and trustworthy
- Respect and protect confidential information
- Make sure that your personal beliefs do not prejudice your patients’ care
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- Avoid abusing your position as a doctor
- Work with colleagues in the ways that best serve patients’ interests

Box 2 Guidance for good medical practice (taken from Good Medical Practice)

Alongside the guidance are the GMC performance procedures, introduced in July 1997 following the enabling legislation by parliament in 1995. The procedures provide the means for the GMC to assess the performance of a doctor whose practice is considered to be poor. Restrictions on registration may be placed on the doctor after a series of steps involving a knowledge based test together with a specialty specific assessment of clinical skills (box 3).

Stage 1: screening
- The GMC receives a complaint about professional performance and undertakes initial assessment
- If there is possible serious deficiency the doctor passes on to stage 2

Stage 2: assessment of performance
- Doctor agrees to, or is required to, undergo assessment
- If performance is judged deficient through assessment, the doctor passes to stage 3 and/or stage 4

Stage 3: remedial action and reassessment
- If deficiencies are remediable, the doctor takes remedial action and undergoes reassessment

Stage 4: committee on professional performance
- Committee considers cases of doctors who refuse to cooperate or whose performance fails to improve or is sufficiently deficient to be dangerous
- Available options for action include suspension of registration

Box 3 How the performance procedures work

The context in which the performance procedures were introduced is fast changing. Within a few months of the formal start of the procedures, quasiregulatory systems and management arrangements in the NHS were introduced by the government, partly in response to concerns over various tragedies related to unacceptable variations in clinical practice (for instance the high mortality rate after complex paediatric cardiothoracic surgery which has resulted in a public enquiry). Now, through the concept of clinical governance, NHS chief executives of hospital trusts (and their boards and senior clinical staff) will be responsible to parliament for the quality of care in hospital.

Additionally, there will be an assessment framework for comparing the performance of health authorities and hospital trusts, the introduction of mandatory clinical audit for hospital doctors, publicly available healthcare outcome results for named hospitals, and, in the future, named hospital doctor clinical audit data will be made available to doctors from the Commission for Health Improvement. All this adds weight to the suggestion that the environment of British medical practice has ‘changed utterly’ and that there may be significant threats to the self regulation of the medical profession as a result of high profile practice failures and changes in perceptions of the role of doctors, at least in so far as policy
makers are concerned. It is in this context of concern over clinical standards that the study reported here was undertaken, during the months after the introduction of the GMC performance procedures in July 1997.

Objectives

The study sets out to categorise senior health professionals' experience with poor medical practice in hospitals and in general practice, to describe perceptions which senior NHS staff have of good medical practice, and to describe how problems of poor medical practice are currently managed. It forms part of a series of studies sponsored by the GMC and designed to evaluate the introduction of the GMC's performance procedures, including also an evaluation of the fairness of the internal processes of the procedures and a study of the beliefs and understanding of a national sample of doctors about good medical practice.

Methods

In November 1997 a postal survey was undertaken of senior NHS doctors and managers who were likely to have a role in the management of doctors whose performance might be considered poor. At the time of the survey these were in:

- Health authorities/boards: the statutory NHS bodies responsible for improving the health of the nation. Directors of public health, general practice medical advisors, and senior complaints managers had responsibility for managing poor performance of general practitioners (GPs)
- Local medical committees: the statutory representative body for GPs, who are independent contractors to the NHS. Medical

Box 4 Procedures for assessing poor performance

1. Informal discussion
2. Work shifting
3. Diverting patient flow
4. Assigning easier cases
5. Exporting the problem
6. Additional education and training
7. “Three wise men”
8. Informal involvement of LMC

Table 1 Number of respondents who had used specific informal mechanisms to handle a poorly performing doctor in the previous two years in general practice and hospital practice, ranked by frequency of use (%)

<table>
<thead>
<tr>
<th>Health authority; n=134</th>
<th>Trust; n=182</th>
<th>Local medical committee; n=73</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Informal discussion</td>
<td>Informal discussion</td>
<td>Informal: local medical committee</td>
</tr>
<tr>
<td>119 (89)</td>
<td>167 (90)</td>
<td>60 (82)</td>
</tr>
<tr>
<td>2 Informal: local medical committee</td>
<td>Additional education</td>
<td>Informal discussion</td>
</tr>
<tr>
<td>99 (74)</td>
<td>93 (51)</td>
<td>57 (78)</td>
</tr>
<tr>
<td>3 Additional education</td>
<td>Work shifting</td>
<td>Work shifting</td>
</tr>
<tr>
<td>98 (74)</td>
<td>89 (49)</td>
<td>30 (41)</td>
</tr>
<tr>
<td>4 Work shifting</td>
<td>3 wise men</td>
<td>3 wise men</td>
</tr>
<tr>
<td>58 (43)</td>
<td>46 (25)</td>
<td>23 (32)</td>
</tr>
<tr>
<td>5 3 wise men</td>
<td>Diverting patients</td>
<td>Additional education</td>
</tr>
<tr>
<td>43 (32)</td>
<td>33 (18)</td>
<td>17 (23)</td>
</tr>
</tbody>
</table>

Table 2 Number of respondents who encountered specific performance problems in the previous two years in general practice and hospital practice, ranked by frequency of experience of problem (%)

<table>
<thead>
<tr>
<th>General practice</th>
<th>Hospital practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health authority; n=134</td>
<td>Health authority; n=134</td>
</tr>
<tr>
<td>Community health council; n=67</td>
<td>Community health council; n=67</td>
</tr>
<tr>
<td>Local medical committee; n=73</td>
<td>Trust; n=182</td>
</tr>
<tr>
<td><strong>Manner and attitude</strong></td>
<td><strong>Manner and attitude</strong></td>
</tr>
<tr>
<td>119 (89)</td>
<td>58 (43)</td>
</tr>
<tr>
<td>Communication</td>
<td>Communication</td>
</tr>
<tr>
<td>110 (82)</td>
<td>65 (97)</td>
</tr>
<tr>
<td>Management and outcome</td>
<td>Management and outcome</td>
</tr>
<tr>
<td>98 (73)</td>
<td>47 (35)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Prescribing</td>
</tr>
<tr>
<td>96 (72)</td>
<td>42 (31)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Prescribing</td>
</tr>
<tr>
<td>92 (69)</td>
<td>35 (26)</td>
</tr>
</tbody>
</table>
Table 3 Number of respondents who considered that a consistent and serious error in the following areas may constitute poor performance (%)

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health authority, n=134</td>
<td>31 (23)</td>
<td>68 (51)</td>
<td>35 (26)</td>
<td>40 (30)</td>
<td>68 (51)</td>
<td>25 (19)</td>
<td>91 (68)</td>
<td>36 (27)</td>
<td>7 (5)</td>
<td>98 (73)</td>
<td>34 (25)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Trust, n=182</td>
<td>60 (33)</td>
<td>86 (47)</td>
<td>35 (19)</td>
<td>66 (36)</td>
<td>96 (53)</td>
<td>20 (11)</td>
<td>153 (84)</td>
<td>25 (14)</td>
<td>4 (2)</td>
<td>140 (77)</td>
<td>38 (21)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Local medical committee, n=97</td>
<td>94 (73)</td>
<td>34 (26)</td>
<td>37 (28)</td>
<td>27 (21)</td>
<td>37 (28)</td>
<td>9 (7)</td>
<td>48 (39)</td>
<td>22 (18)</td>
<td>3 (2)</td>
<td>48 (39)</td>
<td>23 (18)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

1=definitely yes; 2=probably yes; 3=probably no.

Results in total, 457 questionnaires were available for analysis, a 48% response rate overall, mainly from clinicians (68% of respondents). Of the clinical respondents, 72% were providing regular care for patients across the whole range of specialties and general practice. Although there were responses from more than one type of health professional in health authorities/boards and in trusts, there were no significant differences between results from different types of respondent within institution type. Results are therefore displayed by institution type.

The overall response rate of institutions was 68%. Analysed by institution that gave at least one response, the response rate was: health authorities/boards 75%, trusts 69%, local medical committees 71%, community health councils 56%.

In each main section of the analysis, results are displayed from the four types of institution because they each have different aspects of poor performance as their priority and may therefore be expected to have experience and opinions of poor medical practice.

Awareness of the performance procedures
All of the respondents had heard of the performance procedures, the principal source of information being the GMC itself.

Experience of handling poorly performing doctors
Respondents were asked whether they had used any informal mechanisms listed in box 3 to handle a poorly performing doctor over the previous two years.

Informal mechanisms
Table 1 indicates that an informal discussion was one of the most frequently used informal mechanisms with 82% of local medical committee respondents, 90% of trust respondents, and 89% of health authority respondents using it on at least one occasion in the previous two years. Providing additional education and training was also a frequently used informal mechanism, as was work shifting (a mechanism which involves relieving the poorly performing doctor of some patients/clinical duties). The remaining mechanisms, for example assigning easier cases or exporting the problem, were used less frequently. Only 15% of health authority and 18% of trust respondents had assigned easier cases to a poorly performing doctor.

Formal mechanisms
Respondents were asked about the formal mechanisms they used to handle poor performance, with 67% of health authority respondents, 57% of trust respondents, 76% of community health council respondents, and 58% of local medical committee respondents having used the existing NHS complaints procedure on at least one occasion in the previous two years. Existing disciplinary procedures had been used slightly less frequently, with almost half of the trusts, community health councils, and local medical committees, and 60% of the health authority, respondents using them on at least one occasion. Fifty five per cent of health authorities, 43% of community health councils, 40% of local medical committees, and 19% of trusts had referred to the GMC health procedures or to conduct procedures on at least one occasion in the previous two years.

Types of performance problems encountered
Respondents were asked whether they had encountered specific types of performance problems in the previous two years. The most frequently encountered performance problems were related to consultation skills (table 2). Health authority respondents answered this question less frequently about hospital practice because the problem of poor performance is usually a matter for the trust.

Perceptions of poor performance
Respondents were asked whether, in their opinion, a consistent and serious error in any
one of five areas of clinical practice would constitute poor performance (table 3). Almost all respondents stated definitely yes or yes when considering prescribing, diagnosis, and outcome. Respondents were less certain, however, about clearly defining consultation skills of manner and attitude and communication as poor performance despite stating that these are the most frequently encountered performance problems (table 2).

Management of doctors with serious and consistent errors of performance
Respondents were asked:

- Should a consistent and serious error in any one of (several) areas trigger a local investigation? and
- If that local investigation fails to resolve poor performance, should referral under the GMC performance procedures be considered?

Results showed a similar pattern to those from the perceptions of poor performance questions about the relative importance attached to specific areas of practice. For example, respondents in 51% of health authorities and 47% of trusts said probably yes to considering whether to trigger a local investigation for manner and attitude whereas respondents in 80% of health authorities and 83% of trusts said definitely yes when considering clinical management and outcome. In the case of referring unresolved performance problems to the GMC, a similar pattern emerged. Respondents showed more reservations about referring serious and consistent errors in relation to the consultation skills of manner and attitude and of communication than about referring poor technical skills.

Discussion
These results form an important baseline for what is perceived to be good medical practice by senior staff in the NHS, against which it will be possible to assess changes in the local handling of poorly performing doctors. In particular the results show that there is a difference in the perceptions of what constitutes poor practice between consultation skills and what might be termed technical skills, even though problems with consultation skills are far more frequently encountered by the study respondents.

Two of the 14 criteria on good medical practice published by the GMC9 are particularly pertinent here (box 2). Doctors are required to “listen to patients and respect their views” and to “give patients information in a way they can understand”. Despite this clear guidance there still seems to be a reluctance to consider doctors as performing poorly if they persistently fail to meet these criteria.

On the basis of this study, mechanisms for the current handling of poorly performing doctors seem rather fragile. Exporting problems or work shifting to colleagues, rather than managing the problem explicitly, may not be in the best interests of patients, employing organisations, or the doctor concerned. It may be that informal mechanisms are in many cases the most appropriate method of handling the poorly performing doctor, but at the very least these mechanisms require a means of ensuring appropriate outcomes. Although the study found that doctors and managers from all parts of the NHS were well informed about the performance procedures it did not follow that appropriate mechanisms were in place to deal with those cases where there are serious concerns over performance. Although no data have been gathered on the outcomes of the informal and formal methods used by respondents to manage poor performance, it is unlikely that these outcomes will be other than those reported by the contributors to the work of Lens and van der Wal,10 nor different from that which led to the introduction of the performance procedures.11

Nevertheless, it is apparent from the results that most of the respondents ascribed to high standards and expectations of technical competence. The sense of frustration in not being able to deal adequately with the types of performance problems so graphically described in Rosenthal’s work,1 may be exacerbated by these high professional standards.

Variation from the norms of good medical practice and persistently poor practice are a concern to local clinicians and managers as well as to regulators and policy makers. When this study was undertaken there was relatively little evidence of preparation by institutions to ensure that they were in a position to use the performance procedures effectively or to put in place mechanisms for early diagnosis and more effective management of poor performance. However, data were collected up to six months before the policy and practice changes arising from the recently highly publicised “Bristol case”15 (in which three doctors had restrictions to practice placed on them for failures in the standards of good practice), recent guidance from the GMC,12 and the NHS quality initiative.13 Responses to these influences may have accelerated change. After the introduction of the performance procedures, Rotherham and colleagues14 produced advice for local managers in health authorities in the case of GPs whose performance gave cause for concern. Many local clinical governance committees are attempting to determine how they should handle poor performance within their brief of quality improvement and risk reduction.

But it should be recognised that the dissonance among professionals in the perception of what constitutes poor performance of a doctor in consultation, in contrast with the more technical aspects of care, is a challenge to patient care and perhaps, ultimately, to medical professional self-regulation. Changes in societal attitudes to doctors who are rude or unhelpful are likely to mean that, in the future, failures of consultation skills are as likely as failures in technical skills to bring a doctor to the attention of local NHS management, and will require clearer mechanisms for handling poor performance. For this situation to be improved, a more positive approach to acknowledging the rights of patients will be required, particularly at all levels of education and training in medical schools and in the NHS.

The information from this study will now be used in a second investigation which will examine the mechanisms for handling poorly
performing doctors in the NHS and the use of referral to the GMC performance procedures in those cases where local handling is deemed to have failed.

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Allen Hutchinson is a member of the GMC performance procedures evaluation group which commissioned the research project.

Copies of the questionnaire are available from the School of Health and Related Research, University of Sheffield, Regent Court, 30 Regent Street, Sheffield S1 4DA (tel: 0114 222 0811).