# Dealing with poor clinical performance

*New proposals are ill thought out and more about politics than policy*

This week the British government announced a new agency, the National Clinical Assessment Authority, to work with doctors and employers to address underperformance and incompetence.[1] The announcement was hasty, following a report that concluded that a British general practitioner, already convicted of 15 murders, might have committed up to 300. Moreover, and despite being in the offing for some time, the report describing the new authority, *Assuring the Quality of Medical Practice*, reads like an end of term report from a government seeking re-election.[2] It was supposed to add flesh to the bones of a consultation document produced by England's chief medical officer 14 months ago, *Supporting Doctors, Protecting Patients*,[3] and tell us how "a system for preventing, recognising and dealing with the poor clinical performance of doctors"[3] would work in practice. In fact, it rehearses a lot about what we already know and tells us little more about how it will all work together.

The diagnosis is not contentious. The current systems in the NHS for dealing with potential poor performance are ad hoc, fragmented, and procedurally tortuous: many concerns are not acted on and others are subject to lengthy delay. There is no clear delineation of the roles and responsibilities of the various organisations involved in governing a doctor's clinical practice. When colleagues, hospital managers, patients, and the health authority had concerns about Rodney Ledward (an errant gynaecologist eventually struck off by the General Medical Council in 1998) they reported being unsure whose responsibility it was to take action or how to amass a case to support their concerns.[4] *Assuring the Quality of Medical Practice* establishes a new path of accountability and, crucially, provides a mechanism for action.

From April employers will be able to refer doctors to the new National Clinical Assessment Authority (NCAA), which will provide assessments of clinical performance when concerns about a doctor are raised. On the basis of clinical data, discussion with the doctor and other staff, and a visit, the assessment authority's team of medical and lay assessors will make a judgment about the doctor's performance and recommend a course of action for the doctor and the employer. In the first instance, responsibility for dealing with problem doctors will rest with employers, who will be expected to act on the assessment authority's recommendations, although they are not bound by them. Only the most serious cases are likely to be referred to the GMC to see whether the doctor's licence to practise should be revoked.

Any attempt to clarify the complex roles of the various organisations involved in governing a doctor's clinical practice is welcome. The assessment authority should boost local accountability and encourage employers to act quickly when there is concern rather than seeking to blame someone in the wake of tragedy. The policy objectives laid out in *Assuring the Quality of Medical Practice* are ambitious. To be achieved they will require the coordination of clinical governance initiatives, proposals for revalidation by the GMC, reform of disciplinary and complaints procedures, and the work of the royal colleges and the Commission for Health Improvement. Though the overall objectives of this policy update are good, there is a surprising lack of detail about how to bring a practical coherence to such a complex web of activities.

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What happens, for example, when there is a dispute? The weak provision of an appeal for doctors through "a process internal to the employing organisation" will not carry much weight—nor may it be fair or compatible with the Human Rights Act. If an employer failed to act on a recommendation from the assessment authority who would hold the employer to account? Protecting patients is central to the policy, but there is little thought given to where they fit into the process. Patients are already confused about whom to go to when things go wrong. More thought is needed on the way in which the different avenues of redress and complaint might be integrated to make the whole system simpler and easier to access. It seems incongruous to propose change without considering the impending report on the review of the NHS complaints procedure.

No report card of progress to date would be complete without the now customary veiled threat to the GMC: to reform or be reformed. It also speaks to the wider community of health professionals and their representative bodies. The selection of positive and supportive comments from the consultation on *Supporting Doctors, Protecting Patients* serves as a barbed pre-election reminder to the profession that it has had its opportunity to have a say and is now implicated in the resulting policy.

Though undoubtedly a step in the right direction, this report smacks of a rushed job. Save announcing the chair and medical director of the new authority there is little information about how it will be funded or staffed or how it might draw on the expertise of groups such as the royal colleges and specialist organisations. It suggests a government under pressure to be seen to do something in the wake of Harold Shipman and in anticipation of the impending reports into professional scandals at Alder Hey and Bristol. In many ways it is a précis of current progress and future promises, describing the government's "record of achievement to improve the protection of patients."[2] It is thus more about politics than policy, and doctors are unlikely to consider this end of term report worthy of top marks.

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1 Clare Dyer. New agency set up to catch incompetent doctors. *BMJ* 2001;322:47.
2 Department of Health. *Assuring the quality of medical practice: implementing supporting doctors protecting patients*. London: Department of Health, 2001.
3 Department of Health. *Supporting doctors, protecting patients: a consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England*. London: Department of Health, 1999.
4 Ritchie J, Mellows H, Chalmers J, Bash J. *The report of the inquiry into quality and practice within the National Health Service arising from the action of Rodney Ledward*. London: Department of Health, 2000.