

Separating the sheep from the goats

Does the medical profession do enough to ensure that every doctor gives his patients an adequate quality of care? Or is there (as is sometimes alleged) a tradition of solidarity that encourages doctors to cover up the deficiencies of their less competent colleagues by a conspiracy of silence?

Three years ago the BMA Board of Science began discussions about medical competence which led to the formation of a committee drawn from the Royal Colleges and Faculties, the Councils for Postgraduate Medical Education, and the BMA. The committee's report,¹ published earlier this week, presents a broad consensus of current views, though some reformers may not think it radical enough.

Competence has become an issue of public concern, as it has become increasingly clear that apparently minor medical errors may be tragic for the individual patient concerned. Inadequate knowledge of side effects may be a disaster when it leads to delay in recognising the causes of agranulocytosis, retinal damage, or fibrinous peritonitis.² Patients with malignant hypertension may die while receiving inadequate or inappropriate drug treatment.³ The pace of change in medicine is such that treatment that was orthodox a year or two ago may be dangerously out of date today. Nowadays no doctor can ignore the need to continue his education throughout his professional lifetime. Furthermore—as the report emphasises—mere attendance at postgraduate lectures is unlikely to be enough. The essence of continuing education, it says, is a critical approach to day-to-day clinical work, augmented by free discussion among colleagues of the experience so gained. The report goes on to recommend that the Royal Colleges and Faculties should make further efforts to encourage and provide peer-group meetings and material for self-assessment as part of their responsibility to their members.

More specific medical audit requires access to medical records, and this, too, the report supports. If records are to be used to evaluate medical care they need to be modified to include the relevant information. Such changes, the committee thought, would be acceptable only if doctors were convinced that analysis of their records would indeed lead to improved standards. Furthermore, the analysis would have to be carried out by the doctors concerned and not by external assessors. This theme of consent runs through the whole report: if auditing procedures are to prove acceptable to the profession, it argues, they must be conducted by the clinicians themselves responsible for the patients concerned without any suggestion of outside supervision or any form of sanctions. It specifically rejects any possibility that reviews of competence should be linked with relicensure or with continuing membership of a college or faculty.

Do these proposals go far enough? Exponents of medical audit⁴ repeatedly emphasise the importance of "closing the feedback loop." By this they mean that mere discussion of deaths and complications is not enough to eliminate any errors that may have been responsible: the errors must be identified and changes in practice agreed that will prevent their repetition. Rigorous audit of that kind is possible within a voluntary, self-regulating system—but that assumes a high level of motivation by all concerned. The crucial problem may turn out to be persuasion of a minority of clinicians who remain in invincible ignorance of the medical winds of change, justifying their isolationist attitudes by parrot-cries of "clinical freedom." But with more and more doctors working in teams their clinical actions are under closer scrutiny. For the time

being at least the first priority should be the wider introduction and development of techniques of audit in the NHS so that they become familiar features of medical practice. Only then will it become apparent whether there is any substantial division into medical sheep and goats.

Unfortunately there is another aspect of quality control in medicine that is threatening to overshadow all else. Shortage of resources is beginning to limit the choice of medical treatment in a way that would have been quite unacceptable even ten years ago. The length of waiting lists acts as a form of rationing for some forms of elective surgery; but there are other treatments—most notoriously dialysis and transplantation for end-stage renal failure⁵ and the implantation of pacemakers⁶—where the gap between the number of patients treated in Britain and elsewhere in Europe suggests that our rationing is excluding some patients at the cost of their lives. This problem clearly worried the committee, which at one point stated: "The need for a doctor to determine priorities in the use of resources under his exclusive responsibility usually involves him in consciously rationing his time and often amending an ideal course of treatment for one of his patients so that others may benefit; but he must have freedom to determine in his own way, by his own judgment, how much weight he will give to the needs of an individual patient to the exclusion of all others."

Again, the philosophy may be questioned. Insistence on absolute standards may be intellectually justifiable, and we need our centres of excellence⁷ (though their numbers may need to be cut), but there comes a time when some compromise has to be made. For much of the history of the NHS there has been competition for resources (in hospital building, for new equipment, for beds, for operating time, for junior staff) and the strong have justified their methods by claiming that their patients benefited. But, as the national cake has got relatively smaller and medical care more complex and more expensive, formal rationing has become essential to protect the weak. Surely, too, it is to the advantage of patients and the profession that the argument about rationing should be conducted in public—as is becoming the case with the proposals for redistribution of resources among NHS regions.^{8,9} A rationing scheme implies decisions on the balance of spending between acute and chronic services, among specialties, and even among treatments. The DHSS will argue that many of these individual decisions are of the kind that should be taken at local level in a democratic service. That argument is an excuse for ducking the unpleasant choices. Rationing means suffering: and the Department must accept its share of responsibility—and its duty to explain to the public what is happening and why.

¹ *Competence to Practise*, the report of the committee of enquiry (Mr E A J Alment chairman) set up for the medical profession in the United Kingdom. London, Committee of Enquiry into Competence to Practise, 1976. Copies available from the committee, 27 Sussex Place, Regent's Park, London NW1. Price £1.

² *British Medical Journal*, 1976, **2**, 1155.

³ Dollery, C T, et al, in *A Question of Quality*, ed G McLachlan. London, Oxford University Press, 1976.

⁴ *British Medical Journal*, 1976, **2**, 714.

⁵ Executive Committee of the Renal Association, *British Medical Journal*, 1976, **2**, 903.

⁶ Sowton, E, *British Medical Journal*, 1976, **2**, 1182.

⁷ *British Medical Journal*, 1976, **2**, 779.

⁸ Department of Health and Social Services, *Sharing Resources for Health in England. Report of the Resource Allocation Working Party*. London, HMSO, 1976.

⁹ Avery Jones, F, *British Medical Journal*, 1976, **2**, 1046.