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Reforming Medical Regulation in the United Kingdom: From Restratification to Governmentality and Beyond

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ABSTRACT

This paper is concerned with contemporary reforms to the institutional body responsible for overseeing the regulation of the medical profession in the United Kingdom: the General Medical Council (GMC). Recently the state has introduced legislation which has changed the organisation of the GMC and how it ensures medical practitioners are fit to practice. It is argued that these changes provide supportive evidence for the restratification thesis. This holds that rank and file practitioners are becoming subject to greater peer appraisal and review as a result of external pressure to reform medical governance and increase professional accountability mechanisms. But it is also noted that reforms in medical regulation are bound up with a broader shift in how good governance is conceptualised and operationalized under neo-liberal mentalities of rule as the state seeks to promote at a distance a certain type of citizen-subject congruent with the enterprise form within the risk saturated conditions associated with high modernity. The paper concludes that it is important to investigate contemporary reforms in the regulation of doctors while also bearing in mind the broader socio-political context so social scientists can better contribute to current debate concerning how best to regulate professional forms of expertise.

Keywords: General Medical Council, Governmentality, Medical Profession, Medical Regulation, Restratification

INTRODUCTION

The medical profession in the United Kingdom (UK) is regulated by the General Medical Council (GMC). The GMC came into being as a result of the 1858 Medical Act. This made it compulsory for all individuals who practice medicine in the UK to obtain state-recognised registration if they wish to work as a licensed medical practitioner. The GMC maintains the register, defining the nature of the qualifications necessary to obtain registration as well as the conditions under which a doctor can be removed from the register. Traditionally membership of the GMC has been dominated by medical elites such as the royal colleges and medical schools. This essentially granted the medical profession a collectively held monopoly over the regulation of doctors (Stacey 2000). Yet the last two decades have seen the introduction of a series of reforms to the GMC. Including the gradual growth in non-medical members. The paper outlines changes made to the GMC as a result of the 2008 Health and Social Care Act and how medical elites have responded to them. It also discusses how social scientists have conceptualised contemporary reforms in medical regulation. In doing so it notes the importance of paying close attention to how rhetorical arguments concerning the tacit and specialist nature of medical expertise are often successfully deployed by medical elites as they seek to maintain some semblance of...
collective professional autonomy and regulatory privileges in the face of greater state-endorsed third party surveillance of their activities (Chamberlain, 2012). The paper concludes by noting the need for social scientists to also pay close attention to how changes in medical regulation take place against a broader background of how good governance is conceptualised and practiced under neo-liberal mentalities of rule.

**Harold Shipman and the 2008 Health and Social Care Act**

The 2008 Health and Social Care Act can be said to represent a watershed in the regulation of the medical profession in the UK. Certainly on the surface it seems to have effectively ended one hundred and fifty years of exclusive medical control over the GMC (Chamberlain 2010). But it would be incorrect to say that medical control of the GMC went completely unchallenged for a century and a half. As the twentieth century progressed, a series of high profile medical malpractice cases reinforced the need to introduce a more stringent system of checks and balances to entrenched medical power and autonomy (Gladstone 2000). For instance, in the 1990s the Royal Bristol Infirmary case saw several children die due to botched procedures which the surgeons involved tried to cover up (and were by and large successful in doing so until a medical colleague finally came forward to report what had happened). Bristol led to significant changes to National Health Service (NHS) governance and performance monitoring systems, including the adoption of clinical governance frameworks to guide health care delivery, alongside the introduction of annual NHS performance appraisal for consultants and general practitioners (Chamberlain 2009). Bristol also reinforced to medical elites such as the royal colleges that they needed to adopt more open and transparent governing regimes which included all the stakeholders involved i.e. patients and other health care professions (Davies 2004). Consequently they set about establishing clearer practice standards that could be operationalized into performance outcomes against which the fitness to practice of members of the profession could be regularly checked (Black 2002). As the then chairman of the GMC, Donald Irvine, noted (2001: 1808), ‘the essence of the new professionalism is clear professional standards’.

Yet the fact of the matter is that the internal reforms initiated by medical elites during this period were felt to be inadequate by the victims of medical malpractice. A tipping point was reached with the case of Harold Shipman, a general practitioner from Hyde in Greater Manchester. During a criminal career spanning three decades Shipman was able to use his position of trust to murder two hundred and fifteen of his patients (Stacey 2000). The watching public, already horrified as Shipman’s story began to unfold, were at a loss to understand why it was not until well after his conviction that the GMC finally struck him off the medical register. It appeared the GMC was acting to protect the rights of Shipman instead of to respect the memory of his victims. This sense of bewilderment rapidly turned to anger when it became clear that Shipman had come before a GMC fitness to practice panel previously for prescription abuse (Gladstone 2000). The GMC had had its chance to stop Shipman from practising medicine, but had decided to let him continue. Whatever the reasons behind the GMC’s decision, the families of Shipman’s victims, patient rights advocacy groups, the media and even government ministers, all began to call for far reaching reforms to medical regulation (Smith 2005).

Undoubtedly the Shipman case played a pivotal role in reinforcing the need to address medical control of the GMC (Chamberlain 2010). Smith (2005: 1174), at the end her subsequent governmental review of the Shipman case, was ‘driven to the conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors lingers on’. She also said that “it seems….that one of the fundamental problems facing the GMC is the perception, shared by many doctors, that it is supposed to be ‘representing’ them. It is
not, it is regulating them....In fact the medical profession has a very effective representative body in the BMA, it does not need – and should not have – two” (Smith 2005: 1176). In 2007 the Health and Social Care White Paper was announced as a result of Smith’s report. This subsequently passed through parliament as the 2008 Health and Social Care Act. The Act introduced several key reforms in medical regulation. Non-medical lay members now have to make up half of the GMC membership. Furthermore an independent system overseen by the Public Appointments Commission was introduced to elect GMC members. While the grounds on which fitness to practice cases are judged was also changed. Such cases have traditionally been judged on the criminal standard: beyond all reasonable doubt. A situation that frequently led commentators to argue the GMC’s disciplinary procedures first and foremost protected doctors (Allsop 2006). But the Act required that such cases now be judged on the civil standard of proof - on the balance of probability. It is argued that this will enable underperforming doctors to be more easily stopped from practicing medicine. While to enhance impartiality and the independence of the hearing process, the Act also required cases be heard by an independent adjudicator, not by members of the GMC (Department of Health 2009).

The Act also introduced what was called a ‘GMC affiliate’ (later known as a ‘Responsible Officer’). This person operates at a local NHS level to coordinate the investigation of patient complaints. They also work with NHS management, the GMC and the royal colleges to implement, at a local level, new arrangements for ensuring every doctor is fit to practice in their chosen specialty. This process is called revalidation (Donaldson 2006). Since the Bristol case doctors had undergone an annual developmental check of their performance as part of the conditions of their NHS employment contract (Black 2002, Chamberlain 2009). But Smith (2005: 1048) felt that this process would not have flagged up Shipman as a risk to patients and did ‘not offer the public protection from underperforming doctors’. Smith argued for the need for a more stringent and rigorous performance appraisal system. As a result, the Act made it compulsory for doctors to pass revalidation to stay on the medical register. The revalidation process involves a mixture of clinical audit, direct observation, simulated tests, knowledge tests, patient feedback and continuing professional development activates (Donaldson 2008). Although originally planned for introduction in 2010, the development and piloting process took somewhat longer than expected, with revalidation finally being introduced nationally on a “roll out” basis in late 2012. It now being expected that this process will be completed by the end of 2016 at the latest.

**A Decline in Medical Autonomy?**

The changes to the GMC introduced by the 2008 Health and Social Care Act undoubtedly present a significant challenge to medical autonomy in the form of collective medical control of the GMC. Some academic commentators, much like doctors themselves, have proclaimed that the reforms introduced by the Act effectively brought an end to the idea that medicine as an autonomous independent profession (Chamberlain 2012). But the viewpoint that there has been a decline in medical autonomy is a long standing one which has existed in various forms ever since the emergence of health care managerialism in the NHS in the late 1970s (White 2001). The rise of hospital management, consumerist ideology and patient rights movements have been held by some commentators to indicate that medicine is being proletarianized or deprofessionalized (Elston 1991). But not all academics have agreed that medical autonomy is in decline. Eliot Friedson in particular has repeatedly noted that the need for doctors to exercise discretion in their work is an issue which is unlikely to disappear due to the complex and highly specialist nature of modern medical expertise (Freidson 1994 2001). Although originally an ardent critic of entrenched medical power Freidson now argues that medical practitioners themselves, not patients and NHS managers, must
ultimately control their work activities (Freidson 2001). Not least of all because the nature of their specialist expertise demands society recognise that in order to do their job effectively professionals have to possess ‘independence of judgement and freedom of action’ (Freidson 2001: 122).

Friedson claims that professional monopolies are ‘more than modes of exploitation or domination they are also social devices for supporting growth and refinement of disciplines and the quality of their practice’ (Freidson 2001: 203). Here he is echoing the view long held by medical practitioners themselves that it is not the principle of professional self-regulation that in itself is unjustifiable, only particular instances where it has been abused. Doctors must now work with the public to make sure such abuses do not happen again (Irvine 2003 2006). It is important to acknowledge that recent moves to reform the GMC by the state have reinforced that they need the cooperation and proactive involvement of medicines elite institutions to achieve their goal. This is because contemporary challenges to professional autonomy have brought to the forefront the fact that the principle of medical self-regulation was first institutionalised in the form of the GMC as it provided a workable solution to the complex problem of ‘how to [both] nurture and control occupations with complex, esoteric knowledge and skill...which provide us with critical personal services’ (Freidson 2001: 220).

It is the dynamic nature of this need to both nurture and control professional expertise which has led Friedson, amongst others, to challenge the viewpoint sometimes found in the social sciences that contemporary reforms in medical regulation provide further evidence for the argument that medical autonomy is in decline (Chamberlain 2012). It was argued that instead of undergoing a period of decline, medicine is in fact undergoing a process of restratification, which is sustaining medical privilege and power. Albeit in a more risk-aware, open and transparent, standards-driven, form (Chamberlain 2009). The process of restratification involves the medical profession becoming increasingly reorganised into more pronounced elite and rank and file strata. Certainly the specialist nature of professional expertise, alongside the concurrent need for professionals to exercise a degree of discretion in their work, does arguably create what can be called a ‘buffer zone’ which protects doctors from outsider surveillance and control (Freidson 2001). Friedson (1994) argued via his restratification thesis that medical elites, such as the royal colleges, increasingly try to exploit this buffer zone as they seek to maintain some semblance of medical autonomy through subjecting rank and file doctors to greater surveillance and control mechanisms.

Undoubtedly medicine’s relationship with the general public is changing. However medicine is not necessarily losing control of its monopoly over its expertise. The development of new techniques to monitor the efficiency of performance and the allocation of resources does not in itself reduce medical autonomy. What matters is whose criteria for evaluation are used and who controls any ensuing action. This is an important point. For to function ideologically as a method of occupational control professionalism requires that occupational members control the technical evaluation of work activities (Stacey 2000). This leads to a situation where while the individual autonomy of doctors is affected by contemporary events the collective institutionalised autonomy of the profession as a whole remains by and large intact, albeit in a transformed form (Friedson 1994). For whatever changes are made to medical regulation process, medical control over entry onto (via medical school and junior doctor training) and exit from (via appraisal of their continue competence) the legally underwritten state approved register of practitioners, will continue for the foreseeable future. For example, take the much vaulted medical competence test known as revalidation. As the paper has already noted this purports to be a thorough assessment of a doctor’s fitness to practice in their chosen medical specialty, which they must pass to stay on the medical register (Donaldson 2008). It is also expected that the process will involve collecting
feedback from patients and management on a doctor’s work performance to enhance transparency and accountability (Catto 2006). However, at a day to day level and beyond, the development of revalidation and its piloting and implementation has been overseen and quality assured by the royal colleges. Not least of all because it is expected that a mixture of clinical audit, direct observation, simulated tests, knowledge tests and continuing professional development activates, will together ensure a doctor is regarded as competent (Chamberlain 2012). Furthermore, it was announced in late 2010 that after undertaking a period of extensive consultation the government does not now see any advantage in removing GMC control over adjudication in medical malpractice fitness to practice cases (Department of Health 2010). The governmental focus for now has moved to ensuring that reforms to the GMC continue to enforce a shift toward a rigorous and fair complaint and fitness to practice adjudication process. Possible options voiced for consultation include a greater focus on the use of rehabilitative measures within the complaints system when concerns about a doctor’s clinical performance exist, alongside the development of a more streamlined GMC tribunal system (Department of Health 2010). Only time will tell what the real affects of such changes will be.

In the final analysis, the state has had to water down its proposals and accept that given the specialised nature of medical expertise peer review remains an essential method by which an individual doctor’s clinical competence can be legitimately assessed and underperformance addressed (Irvine 2003, Catto 2006 2007). Furthermore, it needs to be acknowledged that there is another reason why the state does not want the GMC abolished: it is a self-funding body paid for by doctors themselves. It is unlikely that the state would agree in the current economic climate to fund an independent body to take over the role of the GMC. The Health and Social Care Act of 2008 did nevertheless put into place checks and balances to medical control over doctors activities. Doctors may still possess more freedom to control their own affairs than other occupations typically do but they are arguably more publicly accountable than they ever have been (Chamberlain 2012). Consequently, and in line with the restratification thesis, the current situation is perhaps best summed up by Moran (1999: 129-30) who says that: ‘…states are more important than ever before, either in the direct surveillance of the profession or in supervising the institutions of surveillance…[this] has not necessarily diminished the power of doctors; but it has profoundly changed the institutional landscape upon which they have to operate’.

**The Governmentality of Performance Appraisal**

Yet the current regulatory landscape also brings to the foreground an important point that has been overlooked by some academics and social commentators who concern themselves with the complex problem of how best to regulate professional forms of expertise. The fact is that contemporary reforms in medical governance are not singularly grounded in the need to transform the nature of medicine’s relationship with the general public through making it more open and publicly accountable. Rather, changes in medical governance are arguably also bound up with shifts in governance more generally, and indeed, are aimed at subject-citizens as much as they are the medical profession (Johnson 1994). That is, they can be said to be bound up with a shift in the conditions under which good governance can be practiced given current economic and socio-political realities. It certainly can be argued that the introduction of performance appraisal tools such as revalidation is just one more example of the internationally recognised trend that, like other occupations and indeed many areas of contemporary social life more generally, doctors are becoming subject to a seemingly ever increasing number of formal calculative regimes which seek to survey and performance manage their practices in order to better economise and risk manage them (Coburn and Willis 2000, Checkland et al 2007, McDonald et al 2008).
Over the last two decades there has been substantial growth in the use of audit and performance appraisal to survey, monitor and manage the activities of experts as well as sections of the general population often regarded by governing elites as particularly economically troublesome and risk heavy (i.e. criminals, the unemployed and so on) (Power 2009). This growing concern with standardisation and transparent accountability is bound up with the re-emergence of liberalism as an economic and political philosophy (Townley 1999). Against this background it has been argued that performance appraisal is a distinctive form of neo-liberal Governmentality: a system of control which utilises surveillance and rationality to turn the object of its gaze into a calculable and administrable subject open to control and risk management (Townley 1993a 1993b, Newton and Findley 1996, Rose 2000). Here appraisal is said to act as an information panopticon, operating through the use of two key panoptic disciplinary mechanisms: normalisation and hierarchy (Zuboff 1988). Normalisation, or normalising judgments, involves comparing, differentiating and homogenizing in relation to assumed norms or standards of what is proper, reasonable, desirable and efficient (Foucault 1991). Appraisal possesses normalising judgements due to its focus upon establishing behavioural norms in the form of ‘on the job’ task standards from which to judge individual performance. Hierarchy involves a process of judging, ranking and rating an individual without in turn being judged (Gordon and Miller, 1991). A point which brings to the foreground the fact that no matter how personally developmental and socially beneficial it is argued to be, it remains an exercise in one group exerting power and control over another. Although this Foucauldian perspective notes appraisals usefulness as a disciplinary tool for identifying and correcting performance, it nevertheless does not hold that it is a straightforward punitive disciplinary tool, solely concerned with identifying and correcting poor performance ‘from the outside’ (Townley 1997). Indeed, it is argued that appraisal may well seek to promote and reward certain behaviours and rectify others, but it nevertheless does so using as far as possible a more subtle and invasive form of soft power (Rose 2000). Certainly, within medicine, appraisal seeks to work on the subjectivity of appraisees at a distance through requiring they engage in self-surveillance of their clinical performance as a result of the availability of best-evidenced clinical guidelines and protocols (Sheaff et al 2003). For example, revalidation requires medical practitioners keep a record of their work activities which contains personalised information relating to prescribing patterns, the outcomes of case note analysis, the results of clinical audit, as well as patient complaint case outcomes and surgical operation success rates (Chamberlain 2012). They must use this information to identify and publicly record areas of personal developmental need in relation to best-practice performance frameworks, guidelines and protocols (Bruce 2007). Furthermore they must subsequently record activities and achievements that demonstrate they are proactively meeting their self-identified learning goals. With this record being subject to subsequent peer review, in order to prove they are willing as a matter of good professionalism to admit to areas of poor performance and learn from them (Irvine 2006). This is why performance appraisal tools such as revalidation are often promoted within medicine on the grounds that they formalise what already should be a normal and everyday part of a doctor’s day to day self-monitoring of their clinical performance (for example, see Snadden and Thomas 1998, Davis et al 2001, Wilkinson et al 2002, Donaldson 2008).

This invasive soft power style of governance is arguably a generic feature of contemporary neo-liberal forms of rule. It has been argued that there has been a profound shift in ‘the nature of the present’ (Rose 1992: 161) and the way ‘[we] come to recognise ourselves and act upon ourselves as certain kinds of subject’ (Rose 1992: 16). Due in no small part to the re-emergence of liberalism and the growing ascendancy of the concept of the enterprise self
throughout all spheres of modern social life (Chamberlain 2012). Burchell (1996) argues that neo-liberalisms dual advocacy of the self-regulating free individual and the free market has led to ‘the generalisation of an “enterprise form” to all forms of conduct’ (Burchell 1996: 28). Enterprise - with its focus upon energy, drive, initiative, self-reliance and personal responsibility - has assumed a near-hegemonic position in the construction of individual identities and the government of organisational and everyday life. Enterprise has assumed ‘an ontological priority’ (du Guy, 1996a: 181). Consequently, as Burchell (1993: 275) notes: ‘one might want to say that the generalization of an “enterprise form” to all forms of conduct – to the conduct of organisations hitherto seen as being non-economic, to the conduct of government, and to the conduct of individuals themselves – constitutes the essential characteristic of this style of government: the promotion of an enterprise culture.’

Against this background it can be argued that given the utility of professional forms of expertise in legitimizing normative governing regimes, changes in how such expertise operates are as much directed towards the object of good governance - the population in general and the individual subject-citizen in particular – as much as they are experts themselves (Rose 2000). That is, contemporary shifts in medical regulation can be seen to be the result of re-alignments undertaken to bring traditionally closed systems of professional governance into sync with shifting conceptions of what constitutes good governance so the state can achieve its broader objective of promoting the enterprise form.

For in terms of Berlin’s (1969) famous dichotomy of ‘positive’ and ‘negative’ liberty, although liberal mentalities of rule may appear at first to promote ‘negative liberty’ (i.e. the personal freedom of the individual-subject to decide who they are and discover what they want to be), in reality they promote ‘positive liberty’ (i.e. that is a view of who and what a citizen-subject is and should be). It certainly can be argued that a key facet of advanced liberal society is its central concern with disciplining the population without recourse to direct or oppressive intervention. Yet liberal mentalities of rule seek to promote good citizenship by discursively constructing and promoting subjective positions for subject-citizens to occupy in relation to the form of the enterprise self. Typically this is associated with a bundle of characteristics such as energy, resilience, initiative, ambition, calculation, self-sufficiency and personal responsibility (Chamberlain 2012). For the world of enterprise valorises the autonomous, productive, self-regulating individual, who is following their own path to self-realisation, and so it requires all society’s citizens ‘come to identify themselves and conceive of their interests in terms of these…words and images’ (du Guy 1996a: 53).

CONCLUSION: RESEARCHING ‘GOOD GOVERNANCE’

This paper has outlined current developments in the regulation of the medical profession in the UK. In doing so it has highlighted how these provide evidence to support the restratification thesis: rank and file doctors are becoming increasingly subject to greater surveillance and performance appraisal by medical elites as a result of external pressure to reform medical regulation and curtail professional autonomy. But perhaps more importantly the paper has also argued for the need for social scientists to contribute to current debates relating to how best to regulate professional forms of expertise while also bearing in mind that such discussions take place against the background of a broader shift in how good governance is conceptualised and operationalized under neo-liberal mentalities of rule as the state seeks to promote at a distance a certain type of citizen-subject congruent with the enterprise form (Rose 1999, Chamberlain 2012). The recent introduction of reforms to the GMC, alongside the introduction of performance management tools such as revalidation, provides an ideal opportunity for the establishment of such a research program. It is undoubtedly important for social scientists to use their expertise to help medical elites strike
a balance between protecting medical autonomy and ensuring medical work remains open to a necessary element of surveillance and control in order to protect the general public from poorly performing doctors. But it is equally important that they do so while also considering the type of citizen-subject and forms of subjectivity promoted and sustained by contemporary governing regimes (Chamberlain, 2011). Not least of all because it is arguable that under the guise of advocating minimal forms of government as the natural way of things, liberal mentalities of rule run the risk of promoting a highly limiting view of what it is to be a human being, let alone a good citizen, within today’s increasingly complex social world. This is a state of affairs that we must all guard against.
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