

After Shipman: reforming the GMC — again

Shortly before Christmas the Shipman Inquiry signed off with the publication of its 1000-page final report, dealing with the big issues of complaints, regulation, revalidation and, behind all that, the role and function of the GMC.¹ The report poses fundamental questions for the whole medical profession and will shape the regulatory framework for many years. Indeed, within days of its publication, it was announced that plans for revalidation were being postponed to take into account the Inquiry's recommendations.

The report is forthright in its criticisms of the way that the GMC has behaved in the past. It documents several examples to justify its central charge that the GMC has acted more to support doctors than to protect the interests of the public. There are numerous recommendations, particularly about the way that the GMC should conduct its business, including, for instance, that there should not be a majority of elected members on the Council, that it should separate completely the investigative and adjudicative functions, and that it should have a much more stringent system for revalidation than the one that was due to be introduced at the time of the report. Crucially, however, the report advocates that the GMC should continue to be responsible for the fitness-to-practice procedures, essentially supporting the basic principle of a self-regulating profession. Dame Janet Smith is to be congratulated for her willingness to adopt the unfashionable line in favour of self-regulation and for spelling out the reasons: that the GMC has changed its procedures in the light of some problems that have already emerged from the high profile scandals of the last few years; that it would be difficult to create an entirely new body to handle fitness-to-practice procedures; and that it makes sense to keep the functions of licensing, revalidation and fitness to practice together as the responsibility of a single body.

While the report leaves the GMC intact, a number of recommendations will bring subtle changes to the relationship between

the profession, its members and the public. For instance, there is concern at the possibility that a doctor could be subject to a number of complaints that have been dealt with by a practice but that would have revealed a pattern of poor standards. The report therefore recommends that primary care organisations (PCOs) should have more responsibility for handling local complaints, including being informed of all complaints made to practices. The apparent good sense of this may not be so welcome in practice, for a number of reasons. First, the experience of some is that PCOs are, in reality, less impressive organisations than they appear, struggling to discharge all their responsibilities with staff who are organisationally immature and changing in composition at bewildering frequency. True, the report recognises that PCOs may lack expertise in this area, and recommend specialist teams acting for several PCOs, but that would add further complexity to an already complex system. Second, removing from patients the option of complaining only to the practice, and making it clear that whatever they want the complaint will be entered on a database held by the PCO, may discourage complaints and reduce this source of feedback. Third, it is another small step towards a more managed service, and away from the original concept of the NHS.² Many will approve, but there must be concerns about the long-term consequences of a managed service where professionals work to strict managerial controls. As a recent King's Fund paper on professionalism put it:

*'An increasingly complex system for ensuring accountability can undermine the professionalism it is supposed to safeguard. Doctors may feel less inclined to behave altruistically if they are excessively scrutinised.'*³

Nor is it only a loss of altruism. The feeling of being continually under scrutiny could have a number of unanticipated effects, such as defensive medicine, with

patients suffering harm as a result. It is also likely to discourage the development of the 'no-blame culture' where we report all medical mishaps in the quest for continual, systematic improvement. Doctors' own internalised standards will always be the strongest driver for high quality medicine and patient safety. All the processes and sanctions in revalidation, complaints and fitness to practice have to work in support, not supplant or, worse still, hinder self-motivation.

The criticisms of the GMC on revalidation illustrate the charge that it has not done enough to protect the interests of patients. The idea that 5-yearly appraisals could provide sufficient reassurance of a doctor's fitness to practice is treated with disdain. Such attitudes betray a touching and outdated faith that the public would trust doctors to be reliable and disinterested judges of their own competence. The RCGP is credited with a more robust attitude, although here too the dependence on a record of performance is seen as essential but not sufficient, and the report recommends adding a test of knowledge. To allow for a more demanding procedure it recommends intervals of every 7 rather than every 5 years.

The report states repeatedly that the GMC needs a change in culture to achieve its purpose. But the idea that it can protect the interests of either the profession or patients is surely wrong. The relationship between doctors and patients has already changed and will continue to do so. It is driven by a better educated public, and by less deferential attitudes towards all its forms of authority. While the research to date shows that achieving shared decision making is difficult, there is a solid consensus to support the intention. If the GMC can extrapolate that to its regulatory functions it will see that it can only maintain or enhance the reputation of the profession by protecting the interests of the patients. Protecting patients' interests must be the GMC's primary purpose, but doing that is the only way of restoring the reputation of

the profession. Operating in the public domain, and with direct accountability to parliament as well as intermittent formal review of its procedures (also recommended in the report), it can only damage itself and the profession if it allows any actions to be interpreted as acting leniently to underperforming doctors. This is the fundamental paradox that we shall all have to embrace: that the trust between ourselves and our patients on which we all depend can only be protected by strict enforcement of tough and demanding standards. Any of us, including me, may fall foul of them at some stage. We must hope that the distinction between human error and recurrent underperformance is one that the GMC can operate consistently and fairly in a way that will not open it, and by

extension the rest of us, to the charge of excessive leniency. Paying for and supporting a body in the hope that it will be tough with us in its imposition of sanctions is difficult, and is perhaps why the GMC is not the only body in the UK contributing to the very low opinion in which professional self-regulation is generally held.

There is one other reason for welcoming the GMC's stay of execution. If this report is going to usher in a new age of a tougher stance towards underperformance, it is likely to be much more acceptable to the profession if it comes from its peers, rather than from some quasi-independent body of lay people. But it had better be tough.

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Human metapneumovirus

Children with respiratory infections frequently present to primary care. For doctors the diagnosis and management of these children is often straightforward — most infections are self-limiting and symptomatic treatment with antipyretics is the standard advice. 'Viral infection' is medical shorthand for saying the child has a minor illness and will recover without an antibiotic prescription. But parents may be dissatisfied with a diagnosis of 'it's just a virus' and their satisfaction with consultation enhanced by a more precise diagnosis and prognostic information about the likely course of the illness.^{1,2}

Using classical microbiological techniques, such as culture and immunofluorescence, a viral aetiology (for example rhinovirus, adenovirus, parainfluenza, influenza, respiratory syncytial virus [RSV]) has been identified in about 60% of children with respiratory infection. Advances in genetic diagnostic techniques, and in particular the use of polymerase chain reaction, have improved our ability to increase the percentage of children for which we can identify a viral cause for their respiratory infection. A significant recent advance in our understanding of the aetiology of viral respiratory infections in children has been the identification of a

commonly acquired, but newly discovered, virus — human metapneumovirus.

Human metapneumovirus was first reported in *Nature* in 2001 by a virology group from Holland.³ They discovered a paromyxovirus, closely related to avian pneumovirus, in 28 children with respiratory infection. Until their discovery avian pneumovirus, which causes rhinotracheitis in turkeys, was the sole member of the metapneumovirus genus to be identified. The larger subfamily of pneumoviruses include, among other viruses, a major player in respiratory infection in children — RSV. What was especially fascinating about their discovery was the demonstration by serological work on stored blood specimens taken in 1958 (from subjects aged 8–99 years) that human metapneumovirus has been circulating for more than 50 years, and that by the age of 5 years virtually all children have been exposed to the virus.

Since publication of the human metapneumovirus genus various groups from around the world have begun to document the incidence of infection and associated clinical features. Researchers from Tennessee retrospectively examined 248 specimens collected between 1976 and 2001 from children with respiratory

infection which had previously tested negative for virus.⁴ Forty-nine (20%) tested positive for human metapneumovirus RNA. They concluded that 12% of respiratory infections in their cohort were attributable to human metapneumovirus.

For most children the virus causes a mild upper respiratory infection. In others an influenza-like illness may result, with fever, myalgia and vomiting. Reports have described bronchiolitis, croup, pneumonia, conjunctivitis, otitis media, febrile seizures, diarrhoea, rash and altered liver function tests following infection. Preterm infants may be more susceptible. Serological evidence of universal exposure suggests that some infections are sub-clinical.

Asthma exacerbations secondary to viral respiratory tract infections and viral associated wheeze in young children commonly present in primary care. A recent Finnish study reported human metapneumovirus in 8% of consecutive children admitted to hospital with acute respiratory wheezing.⁵ In 70% of these children human metapneumovirus was the sole viral agent. Larger studies are required to determine the morbidity resulting from infection in children with asthma, but it is clear that this newly discovered virus has an important role in causing wheeze.