Editorials

Lifting the dead hand on general practice

According to the Professional Standards Authority (PSA) *'it is primarily the professionalism of individuals that keeps the public safe …'*.[1] But GPs find it increasingly difficult to exercise professionalism with the current workload pressures.[2] Part of the problem is over-regulation and bureaucracy, and recently NHS England, the Care Quality Commission (CQC), and the General Medical Council (GMC) called for action to lessen the burden.[3] Any reduction will help, but it may prove more important to understand the culture that drives over-regulation. We seem to be locked in a vicious cycle that undermines professionalism. With every stepwise increase in workload comes further micro-management and control, which make matters worse. Only by understanding the mechanics of this damaging cycle, can we change the culture of control to one that makes better use of the most valuable resource in the NHS: the professionalism of its workforce.

WHEN CONTROL SYSTEMS BACKFIRE

Sanfey and Ahluwalia have described a fear-avoidance cycle that emerges whenever a prevailing regulatory culture is seen as oppressive or punitive.[4] Doctors become reluctant to openly investigate and correct flaws in the care they deliver. Without self-correction by professionals, regulators feel compelled to impose external controls, which generate yet more fear, and so on. A similar vicious cycle may also be driving up costs. In advanced economies, up to 30% of total healthcare spending can be medically unnecessary.[5] In the UK, defensive practice is rising inexorably, driven largely by fear,[6] and increasing the proportion of unnecessary referrals, investigations, and prescriptions.[7] Economic models however, are very poor at distinguishing necessary from unnecessary healthcare.[5] They interpret the rise in medical interventions as increased patient demand, which means a vicious cycle can develop when methods for controlling expenditure also increase medically unnecessary interventions.

Staff and tariff costs were targeted to improve productivity in the first Quality, Innovation, Productivity, and Prevention programme (QIPP) from 2010–2015. Cutting pay causes stress, which together with excessive workload, burnout, and risk-aversion is known to generate unnecessary referrals, prescriptions, and investigations.[8,9]

> *"… it is possible that our current approaches to patient safety and cost containment are counter-productive precisely because they undermine professional decision-making."*

The pay cuts were motivated by the central role of productivity in the Nicholson report.[10] Productivity measures the value of a product in relation to production costs. This is all very well, provided the product is a good thing, and provided it correlates with the better health and wellbeing of the population. But in health care, the product is dominated by the volume of drugs, tests, operations, and procedures ordered by clinicians, not by the improved health and wellbeing of citizens.[11] Referral rates by GPs vary enormously, with risk-aversion being the main determining factor,[12] and with little evidence that higher referral or investigation rates produce better outcomes for patients.[13] The same appears true for hospital doctors.[14] Productivity is blind to the meaning of clinician-induced variations in patient demand. It cannot distinguish legitimate demand from 'failure demand', namely the demand for services produced by risk-averse or otherwise dysfunctional decision-making earlier in the patient journey. Whenever clinical expertise prevents unnecessary interventions, productivity sees no outcomes to measure, but still sees the cost of the expert.

Referrals and prescriptions have continued to rise inexorably during the QIPP years. How much of this is failure demand remains uncertain, but it is possible that our current approaches to patient safety and cost containment are counter-productive precisely because they undermine professional decision-making. Which begs the question: is there a viable alternative that empowers professionalism?

UNSHACKLING PROFESSIONALISM, SAFELY

A new assurance framework that supports professional expertise will need to accommodate two mutually contradictory requirements. To unleash the potential for efficiency, it must liberate professionalism from micromanagement. On the other hand, professionals must be accountable, with some formal system that can identify unacceptable variations in quality. Two recent developments lay the foundations to achieve this balance. The first is the outcomes-based approach of the Five Year Forward View, (FYFV).[15] The second comes from the PSA's insight into the nature of professionalism in terms of expertise in risk management.[1]

The FYFV introduced Accountable Care Organisations (ACO) as a new model of care, in which primary, secondary, and social care providers share a capitation-based budget, and where the 'product' is defined by population health outcomes not the volume of interventions. This health outcome approach should in principle, reduce the unintended incentives for risk-averse decision-making. It should also play to the strengths of GPs with their population-based clinical systems and generalist principles.

A population outcome approach is one important enabler for the paradigm shift we need in our regulatory system. Understanding how expert professionals manage risk safely is the other. Professionalism has been defined by the 'values, behaviours, and relationships that underpins the trust the public has in doctors.'[16] For individual professionals, trust is built upon confidence that risks are understood and managed with sensible, agreed actions, and if something goes wrong, it will be detected and corrected in good time. For the profession as a whole, trust requires confidence that intolerable variations in quality are detected and remedied promptly. In summary, a regulatory assurance system that supports professionalism must know that risks are detected effectively, and once detected, are correctly diagnosed and remediated.

A recent paper by Chris Ham describes many of the qualities of high-functioning organisations in other countries.[17] Intermountain Healthcare, Virginia Mason Institute, and others have learned increasingly to value and trust the professionalism of clinical decision-makers. These organisations are characterised by

"Top-down management has become costly and counter-productive. High-quality clinical decision-making is the most powerful resource in the NHS and should be valued and nurtured."

a low-blame culture. They have an open approach to learning from mistakes and adverse outcomes, and report a reduced incidence of mistakes and complaints.[18] Clinicians in higher-performing teams are typically open to rapid and meaningful feedback to guide their actions, and feel empowered to deviate from guidelines using judgement to escape a tyranny of algorithms, rather as Launer and Greenhalgh have called for in general practice.[19,20] The combination of professional empowerment with an open approach to learning, challenge, and dynamic feedback is characteristic of these provider organisations.

A NEW REGULATORY CULTURE

The shift from a controlling culture to one that values expertise requires no new legislation, just a change in mindset. Experienced clinicians are in the best position to rectify flaws in the healthcare they deliver, and managers would be better deployed developing quality improvement and information systems, and supporting clinicians to identify, understand, and remediate risks in the services they provide. Conversations aimed at reaching a shared understanding and common purpose with frontline providers become more important than complex agreements laden with performance indicators. In effect, local managers and providers should aim to develop trusting, collaborative relationships and become self-correcting teams that earn increasing autonomy. As long as teams openly share information within the wider system, especially about risks identified, and as long as they respond professionally to challenge, and their outcomes are good, self-correcting individuals and teams can be self-directed.

Openness is essential if earned autonomy for self-correcting systems is to succeed safely. The overarching system for patient safety assurance must have confidence that risks are being identified and remediated effectively and that system learning takes place.

Top-down management has become costly and counter-productive. High-quality clinical decision-making is the most powerful resource in the NHS and should be valued and nurtured. The bulk of NHS spending as well as patient safety is determined by joint decisions taken in primary care consultations. The shift to population outcome contracts for collaborating provider organisations is a great opportunity for general practice. As generalists, we are both well placed and best qualified to lead the development of new clinical models and the integration of fragmented systems across diagnostic and professional boundaries. The door has opened for us to demonstrate bottom-up leadership.

ADDRESS FOR CORRESPONDENCE

John Sanfey
20 Dawes Road, Fulham, London, SW6 7EN, UK.
E-mail: johnsanfey@nhs.net

John Sanfey,
Medical Director, Hammersmith and Fulham GP Federation, London. Supplier to GP Resilience Programme — Renervate. Freelance GP, South Central London Pallant Chambers.

Sanjiv Ahluwalia
GP, Watling Medical Centre, Burnt Oak, London.

Provenance
Commissioned; not externally peer reviewed.

DOI: https://doi.org/10.3399/bjgp17X693989

REFERENCES

1. Professional Standards Authority. *Right touch regulation* (Revised). PSA, 2015. http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf (accessed 24 Nov 2017).
2. NHS England. *General Practice Forward View*. 2016. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf (accessed 24 Nov 2017).
3. NHS England, General Medical Council, Care Quality Commission. *Reducing the workload and duplication associated with the regulation of General Practice in England*. 2016. https://www.england.nhs.uk/wp-content/uploads/2016/04/gp-reduce-dup.pdf (accessed 24 Nov 2017).
4. Sanfey J, Ahluwalia S. Re-awakening professional identity: the path to a self-correcting NHS. *Br J Gen Pract* 2016. DOI: https://doi.org/10.3399/bjgp16X686713.
5. Brownlee S, Chalkidou K, Doust J, Elshaug A, *et al*. Evidence for overuse of medical services around the world. *Lancet* 2017; **390(10090):** 156–168.
6. Stephenson T. House of Commons, Health Committee Hearing HC846. 2015. http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/2015-accountability-hearing-with-the-general-medical-council/oral/17274.html (accessed 24 Nov 2017).
7. Bourne T, Wynants L, Peters M, *et al*. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open* 2015; **4:** e006687.
8. Calderwood C. *Chief Medical Officer's Annual Report 2014-15. Realistic medicine*. NHS Scotland, 2016. http://www.gov.scot/Resource/0049/00492520.pdf (accessed 5 Dec 2017).
9. Bachman KH, Freeborn DK. HMO physicians' use of referrals. *Soc Sci Med* 1999; **48(4):** 547–557.
10. Nicholson D. *The Year: NHS Chief Executive's Annual Report 2008/09*. London: Department of Health, 2009.
11. Office for National Statistics. *Correction notice. Public service output, inputs and productivity: healthcare*. ONS, 2011. www.ons.gov.uk/ons/rel/psa/public-service-productivity/healthcare-2011/public-service-output--input-and-productivity.pdf (accessed 8 December 2017).
12. Calnan M. Payne S. Kemple T, *et al*. A qualitative study exploring variations in GPs' out-of-hours referrals to hospital. *Br J Gen Pract* 2007; **57 (542):** 706–713.
13. Foot C, Naylor C, Imison C. *The Quality of GP Diagnosis and Referral. An Inquiry into the Quality of General Practice in England*. 2010. The Kings fund, 2010. https://www.kingsfund.org.uk/sites/default/files/Diagnosis%20and%20referral.pdf (accessed 5 Dec 2017).
14. Tsugawa Y, Jha A, Newhouse J, *et al*. Variation in physician spending and association with patient outcomes. *JAMA Intern Med* 2017; **177(5):** 675-682.
15. NHS England. *Five Year Forward View*. 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 5 Dec 2017).
16. Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. 2005.
17. Ham C. *Reforming the NHS from within. Beyond hierarchy, inspection and markets*. The Kings Fund, 2014. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf (accessed 5 Dec 2017).
18. Syed M. *Black Box Thinking*. London: John Murray, 2016.
19. Launer J. Is there a crisis in clinical consultations? *Postgrad Med J*, 2017; **93:** 58.
20. Greenhalgh P, Howick J, Maskrey M, Evidence based medicine: A movement in crisis? 2014. *BMJ* 2014; **348:** g3725.