Professional accountability in a changing world

The context in which medicine is practised in Britain has changed beyond all recognition since the profession took its first strides into the comprehensive system of health care enshrined in the postwar ideal of a national health service.

For the first 40 years of the National Health Service the accountability of doctors was to their patients and to a broad and non-specific professional code. The NHS at first provided a setting where doctors could “exercise their skills with almost complete autonomy”.

There has been a major change of emphasis during the last 15 years. The advent of managed care in the mid-1980s led to clinicians gaining responsibility and accountability for their own budgets and for service directorates at a time when there were few existing channels of accountability. In the early 1990s charters and service quality guarantees were generated as the rights of service users were acknowledged, defined, and documented. The philosophy of evidence based medicine raised an expectation and created the requirement that clinical decisions be based on what was known to be effective, rather than on individual clinical preference. This was operationalised partly through the production of evidence based guidelines for an increasing number of diseases and patient groups.

The last decade has brought a broader exposition of the principles of good practice and conduct. In so doing an obligation has been placed on clinicians to meet more explicit and higher professional standards. A statutory duty of quality placed on all NHS organisations in the late 1990s is being implemented through the concept of clinical governance.

All these changes have highlighted the duty of clinicians to continuously strive to develop professionally—to acquire and retain clinical skills, to access and use best evidence, to participate in planning for quality, and to evaluate and optimise processes of care.

New and explicit forms of accountability have been required and captured in the concept of clinical governance. This new accountability has redefined the relationship of doctors with the public, with their patients, and with their employer.

Box 1: Accountability

The obligation of one party to provide a justification and to be held responsible for its actions by another interested party.

This paper discusses the nature of professional accountability in this new context and explores its potential as a positive influence in achieving still higher quality care for patients.

Perceptions of accountability

There are many models of accountability, but one way to view it is as having three components:

1. The individual’s professional accountability for the quality of his or her own work.
2. The accountability of health professionals within the organisations in which they work.
3. Accountability (with others), as a senior member of staff, for the organisation’s performance and more widely for its provision of local services.

Many definitions of accountability convey the notion of holding someone (or some organisation) responsible for failure to deliver services to an appropriate standard (box 1).

There is certainly justification for a clear vision in dealing with quality and accountability. The 1990s saw increasing media coverage of serious service failures in the NHS. For example, the Birmingham bone tumour service where misdiagnoses were made, poor organisation of some women’s cancer screening services in which the presence of cancer was not identified, and the Bristol children’s heart surgery service. While uncommon in proportion to the total amount of care delivered, they none the less raised issues of accountability. So too did widely publicised reports of the small proportion of doctors who exhibited poor performance. More recently the case of Harold Shipman, a general practitioner convicted of murdering 15 of his patients, led to public outcry with questions again being raised about accountability of public services.

While such catastrophes are uncommon in the context of the total healthcare provided by the NHS, they are deeply troubling and have created an expectation that the NHS and the medical profession will provide public reassurance.
that they have developed solutions to reduce the risks to future patients of such events.

Looked at in this broader context there are a wide range of claims on the accountability of health professionals whether formally in the courts or to an employer or less formally through media scrutiny of actions or decisions (box 2).

**Accountability and quality**

The 1997 NHS white paper made accountability a statutory duty; “no longer is it acceptable for managerial and clinical leadership to view quality as discretionary”.14 The implementation of clinical governance has married accountability with quality.

A health professional may be said to be accountable for:

- For maintaining the highest standards
- For assessing risk and avoiding failure
- For organisational aspects of quality service provision such as team work, delivering corporate goals, running an accessible service
- For continuous and sustained quality improvement

A new framework for quality within the NHS has established an important context in which medical practice will take place in the new century.15 At its heart is the concept of clinical governance which sets out a requirement for all local NHS services to establish the culture, the systems, and the leadership which will enable quality to be assessed and opportunities for improvement identified and pursued.

The emphasis is on a multiprofessional approach, involving patients and using good information to judge quality.

Doctors as well as all other health professionals will be expected to participate fully in the clinical governance arrangements in the organisations where they work as well as taking on leadership roles within the implementation process.

Local clinical governance is reinforced and supported by an integrated package of new national structures and processes. National service frameworks (NSFs) are transforming whole areas of service, on a nationwide basis. NSFs already cover coronary heart disease and mental health.16 17 They set standards and describe models of best practice. More NSFs are planned. The National Institute for Clinical Excellence (NICE) also has a standard setting role. It is providing clarity to the NHS on which treatments are the most clinically and cost effective, focussing on national NHS priorities. National surveys of NHS patients are now being published annually, again following NHS priority areas; this year’s survey—of coronary heart disease patients—is now well underway. The Commission for Health Improvement (CHI) fulfils an independent scrutiny function for the new quality arrangements. A rolling NHS-wide programme of local reviews with published findings will enable the implementation and adequacy of clinical governance to be assessed.

All NHS staff will also be expected to help embed a culture of safety within every NHS organisation, as a part of their commitment to clinical governance. The study of organisational failure and medical errors has led to the realisation that they are far more often system based than due to the actions of a single individual.18 So, while an individual doctor is responsible for ensuring that his or her practice is safe, there is a wider accountability for ensuring that adverse events as well as “near misses” are recognised and reported so that lessons are learned and clinical risks can be reduced. A growing awareness of these issues as well as of the scale and cost of errors in the NHS led to a report of an expert group on learning from adverse events in the NHS.19

The extension of the concept of individual accountability for performance is reflected in the proposal for routine annual appraisal of all doctors.20 Appraisal is an important contribution to the quality agenda, it offers a forum in which good work can be recognised, strengths acknowledged and built on, and problems identified and tackled. It offers the opportunity for structured personal and professional development plans. At the same time the General Medical Council is developing its own proposals for the five yearly revalidation of all registered medical practitioners.21 As part of this process, doctors will need to create folders of evidence and information which attest to their good medical practice. There are important links to the NHS system of appraisal where the processes will be designed to act as the vehicle through which good practice can be confirmed and revalidation delivered.

Proposals within the NHS Plan22 strongly promote the rights and expectations of patients as consumers of health services expanding the notion of accountability to patients far beyond its traditional base.

**Conclusion**

Tomorrow’s doctor will be working within a much more extensive framework of accountability than yesterday’s. Some of the transition has already been made over the last few years as doctors have responded to and accepted the more explicit professional standards which now exist and the commitment to the NHS quality agenda. Discharging this more diverse form of accountability brings with it responsibility to a new style of practice—more multidisciplinary, more patient participation and more evidence based. Finally, accountability can no longer be seen as

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**Box 2: Those with a claim on accountability**

- Patients
- Patient advocates
- Patient representative organisations
- Employers
- Professional regulatory bodies
- The courts
- Inquiries
- Elected politicians
- The media
- The wider general public

**Figure 1** Key elements of accountability for a NHS clinician.
entirely a matter for the individual practitioner. Health organisations too have a responsibility to provide the culture, the support, and the systems so that the individual practitioner’s accountability for providing high quality care can be delivered.

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