Editorial

Changing practice in health care

The NHS Plan insists that the health service must change. It is “a 1940’s system operating in a 21st century world”. But are the politicians pushing at an open door? Health care practitioners, after all, are adjusting to the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement, and clinical governance. They are working with radically redesigned structures in primary care. In the space of a decade or less, the demand for evidence based practice has spawned new institutes, journals, and information channels and affected practice in each and every health care setting. Indeed, some might be tempted to argue that it is limited government funding for research and innovation that puts a brake on change.

Yet practice is also shifting in ways that engage with and sometimes collide with broader social changes. One sign of the times is when patients appear for a consultation with material they have downloaded from the internet or when they act jointly as part of a group of sufferers or service users to demand changes in the form of practice or the way it is delivered. Another is the crescendo of criticism of the General Medical Council (GMC) as one case after another has hit the headlines. Ways of doing things that have never been in question, suddenly seem no longer serviceable. Overused and overly simple as it may be, the call for “modernisation” demands a considered response.

I would single out three areas that need conscious efforts at consensus building if we are to build appropriate 21st century institutions and cope with the conflicts and tensions of social change in a constructive way. They relate to public accountability, interdependence, and diversity.

Public accountability was played down in the design of the postwar welfare state. The culture of the time placed faith in the power of a bureaucratic machinery to deliver the promises of elected politicians. Trust in the expertise of professionals in education, welfare, and health was part and parcel of this, and financial and organisational support was forthcoming. Thirty years on, the prevailing wisdom had changed. For Conservatives there was more faith to be had in the market than in central planning and entrepreneurialism and more active management and monitoring of professionals was the order of the day. With Labour in power since 1997, the market emphasis has gone, but the reliance on regulation, in the shape of audit, inspection, and performance review has intensified. Informal, indirect, peer based controls on medical performance—seen as entirely justifiable in an earlier era—have come under hostile scrutiny. Coupled with repeated revelations about incompetent doctors, the change of heart has been dramatic. The public may still express their faith in doctors, but the politicians and the press, in medicine and elsewhere, want proof that experts should run their own affairs.

It is this abrupt withdrawal of trust and the accompanying quest for new kinds of accountability that lies behind the present government’s multiple institutions of monitoring and review and the ongoing media debate about the adequacy of self regulation. Tensions apparent in local clinical governance, unease over clinical guidelines, the many forms of inspection and review are all indicators of a regulatory regime in danger of swinging from total trust to no trust at all.

A workable framework of accountability needs to satisfy both patients and governments and have the support of professionals too. The regulatory reforms that the Merrison Committee endorsed for medicine in the 1970s came in what were probably the last moments of the high trust era. They left the concepts of workplace autonomy and collective self regulation of a profession intact. Elitist and exclusive selection practices and the long, heroic struggle for the few to reach the pinnacles of the profession were relied upon to instil a lifetime of appropriate values, commitment, and competence. They gave doctors a sense that they were special and apart—dealing with uncertainties and life and death risks that their patients often could not or would not confront. A new look at the unwritten contract that defines the doctor’s role and a real effort to redraw it are needed if the actual contracts and systems of accountability, represented by revalidation and the like, are to work. Acknowledging the uncertainty that will always surround medical interventions and promoting rather more grown up patients and rather more grown down doctors is one part of this. Devising procedures in the new institutions that treat people neither all as knaves nor all as knights, is another.

Interdependence, the second major theme, presents a confusing prospect. On the one hand, there is widespread acceptance of the importance of the health care team and of the active participation of the patient. On the other hand, medical culture and NHS organisation often work against it. Individual accountability in law when things go
wrong and the clinical autonomy of the medical practitioner has been a taken for granted underpinning of health care practice. It cements divisions within the team, encouraging an autocratic tendency among doctors and a cautious, rule-bound mentality on the part of others. Government has addressed this in an indirect fashion. It is frustrated with “flexibilities” and sees health professionals as retreating into their separate professional silos. Its answer is “workforce reconfiguration”, new roles, and easier movements across and between the old ones. In its future scenario, a teenager with an eating disorder visits his general practitioner (GP). The GP consults the PCT protocol and refers him to a clinical practitioner, who manages much of his care. The clinical practitioner is a mental health nurse with “bolt-on” modules of approved training in psychology and nutritional science. Working to a flexible monthly hours contract, she is able give some weekend support to the teenager at home. She can call on the GP for further support. She attends regular training sessions led by a local specialist psychiatrist. She can bring in social services support where necessary. NICE reinforces some of the messages with its observation that the pace of scientific and clinical discovery is already such that no individual clinical practitioner can remain at the forefront of all the conditions with which she or he has to deal.

Innovative roles are already in place, particularly in nursing and in the professions allied to medicine. The Royal College of Physicians, facing with workload pressure, has recently lent its weight to the idea of an entirely new health care practitioner, working alongside doctors and nurses, taking clinical responsibility for an agreed caseload. But real workforce reconfiguration has some high hurdles to jump. The innovators are positive. But they also report that colleagues fail to understand their skills and potential contribution, that patterns of accountability are muddled, and that they themselves are lacking in support. Calls for “better teamwork” and “more effective communication” are being replaced by a realisation that “culture change” is needed to embed new practices effectively. Consider, for example, the fond recall that those in senior positions in medicine sometimes have for the tacit skills, and instilling them in the relevant parties in ways more relevant to the modern era. There are too many legacies of forms of thought that celebrate individualism and hierarchical distance, and value apparent independence over actual interdependence.

If interdependence and accountability are two key issues underlying changing practice in health care, a third is value diversity. The press criticism in the recent period has centred on cases of individual doctors brought before the GMC. But such cases have begun to raise broader issues, of the lack of respect accorded to women in the case of Ledward, and of the potential for discrimination against doctors from ethnic minorities, a subject where the GMC itself has encouraged and taken part in research. Strong questioning of existing practice has also emerged on other fronts. The nature of acceptable research with babies and the mechanisms for obtaining of informed consent hit the headlines in one setting, long used procedures for disposal of fetal material were challenged in another. Departmental guidance on controversial matters such as organ retention, and when not to resuscitate, is on the increase. Events such as these indicate that the “postwar settlement” that deferred to professional expertise and left it laced with other kinds of authority—of class, gender, and “race”—is now in question. A taken for granted value consensus is thus harder to maintain. As social change takes hold, traditional professional elites find themselves sitting alongside new recruits to the many bodies that take part in policymaking and policy advice in the health sphere. And these recruits think differently. In 1993, for example, after the legislative changes that increased direct elections to the UK Central Council, an induction session found officers and members in fundamental debate. Accepting that the key role was protection of the public, was there not also a responsibility to support nurses by strong guidance on minimal staffing or by insisting that provision for clinical supervision should be in place in the NHS? Those with a trade union background and those close to the front line thought so. They found it difficult to appreciate what it was that the old hands were saying.

Diversity brings a need for ways of working that involve spelling out first principles, rather than working informally and taking for granted “what we all know and share”. Government strategy is now deliberately to include different voices into the policy process. The Partners Council for NICE, the increasing proportions of lay members on the regulatory bodies, the insistence in the NHS Plan on local authority scrutiny committees, are a few examples. All this requires new attitudes, new skills, and perhaps new kinds of committee etiquette. Realising that participants have different kinds of expertise and experience to bring, using the skills of active listening, of mediation, of holding conflict, and seeing compromise as a positive yet sometimes temporary outcome—these are some of the factors that need to be at work. Without them, there will be more and more stories of angry and articulate patient groups and equally angry, bewildered, and hurt professionals.

Alongside continuing medical education, with its focus on evidence based clinical practice, doctors deserve the kind of continuing professional development that addresses the changes discussed here more directly than hitherto. It needs to draw on the insights that history, social sciences, and policy analysis can offer. Continuing professional development also needs, wherever it can, to bring a wide spectrum of practitioners and managers together and foster new thinking about changing practice. New leadership programmes are important. But we also need practitioners in the front line with broader understandings of how practice is changing, who can be constructively critical, and who can model the skills of working with diversity without reliance on traditional forms of authority. Times of turmoil are painful, but the disruptions they bring give space to imagine new futures and to begin to put them into place.

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Robert Loeb (1895–1973) was born in Chicago, son of Nobel laureate biologist, Dr Jacques Loeb. He graduated from Harvard in 1919 and eventually became Samuel Bard Professor of Medicine at the College of Physicians and Surgeons, Columbia University. In 1932 he first demonstrated the role of the adrenal glands in the control of salt and water metabolism in man, and went on to show its importance in Addison’s disease and in diabetes. He was coeditor of the Cecil-Loeb textbook of medicine. In 1962 he was visiting Regius Professor of Medicine at Oxford. His funeral service was held on 25 October 1973 at New York City’s Brick Presbyterian Church.—D G James
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