Chapter Eight

Regulating for Safer Doctors in the Risk Society

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Abstract

This chapter 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 this demonstrates 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, neoliberalism, the enterprise self, positive and negative liberty

Introduction

> "Modern individuals are not merely 'free to choose', but obliged to be free, to understand and enact their lives in terms of choice".
>
> Rose (1999: 87)

The analysis of medicine and risk is indelibly linked to a core disciplinary concern within sociology with the nature of 'good governance' and 'good citizenship' (Rose 1999). This chapter discusses recent developments in medical governance in relation to two key 'schools of thought' concerned with the analysis of risk in today's society – respectively, the 'risk society' and the 'governmentality' perspectives (Lupton 1999). In doing so my aim is not to offer a definitive critical analysis of these viewpoints concerning medical risk. To do so would take up considerably more space than is available. Rather, I seek to achieve two inter-related goals by highlighting points of agreement between the risk society and governmentality perspectives. First, I aim to reinforce the importance of paying close attention to the type of subject-citizen promoted by 'liberal mentalities of rule' as they seek to minimize risks threatening the wealth, health, happiness and security of the population (Rose and Millar 1992). Second, I aim to establish areas for further empirical investigation in relation to medical governance. For in spite of repeated calls for investigation into doctors training and regulatory arrangements (i.e. Elston 1991 2004) little empirical research has been published on this topic (Chamberlain 2008).

Sociologists who concerned themselves with the analysis of expertise at the beginning of the twentieth century by and large possessed an uncritical acceptance of professional practitioner's altruistic claim to place the needs of their clients above their own material self-

interest (McDonald 1995). In doing so they reflected the social mores of the time, which dictated that the good patient play a subservient role during doctor-patient encounters, in much the same way that the good citizen knew their place within the established oligarchic governing order (Moran 2004). But times have changed. Over the last four decades sociologists have become more critical of professional practitioners altruistic claims (Friedson 2001). An ever-growing series of high profile malpractice cases - such as the general practitioner Harold Shipman who murdered over 215 of his patients - have reinforced to sociologists the need to advocate the adoption of more open, transparent and publicly accountable governing regimes (Davies 2004). Furthermore, the public now expects to play a significant role in treatment decision-making and planning, just as they expect to have their voices heard and opinions listened to by their democratically elected political leaders (Lupton 1999). They refuse to accept the legitimacy of the traditional elitist and paternalistic view of professional and state forms of governance, which dominated western societies until relatively recently (Moran 2004). As the following discussion of the rise of the risk society will highlight, underlying recent reforms in medical governance is a more fundamental shift in the conditions under which good governance and good citizenship can be practiced as a result of the economic and political re-emergence of liberalism (Rose and Miller 1992).

The political re-emergence of liberalism

> "I think we've been through a period where too many people have been given to understand that if they have a problem, it's the government's job to cope with it. "I have a problem. I'll get a grant". "I'm homeless, the government must house me". They're casting their problem on society. And, you know, there is no such thing as society. There are individual men and women, and there are families. And no

> government can do anything except through people, and people must look to themselves first. It is our duty to look after ourselves, and then to look after our neighbour". Thatcher (1987: 10)

/The 1970s saw the renewal of liberalism as an economic and political ideology, with its emphasis on enterprise and individualism, advocacy of 'rolling back the state', and belief in the ability of the discipline of the market to promote consumer choice, improve service quality and minimise risk (Elston 1991). The neo-liberalism of Margaret Thatcher's conservative government of 1979 possessed an overriding concern for the '3 Es' - economy, efficiency and effectiveness – and had its ideological roots in classical liberalism (Rhodes 1994). This emerged in the seventeenth and eighteenth centuries, through the works of a variety of writers, such as Thomas Hobbes, John Stuart Mills, Adam Smith, Thomas Locke, Jeremy Bentham and Herbert Spencer. The concept of 'possessive individualism' lies at the heart of classical liberalism (Macpherson 1962). Macpherson (1962) argues that for these thinkers the individual and her capabilities 'pre-figure' the circumstance into which she is born. In short, her talents and who she is owes nothing to society, rather she owns herself, and she is morally and legally responsible for herself and herself alone. She is naturally self-reliant and free from dependence on others. She need only enter into relationships with others because they help her pursue her self-interests. According to this viewpoint, society is seen as a series of market-based relations made between self-interested subjects who are actively pursuing their own interests. Only by recognising and supporting this position politically and economically will the greatest happiness for the greatest number be achieved. Classical liberalism is a critique of state reason which seeks to set limits on state power (Peters 2001).

A very real problem here is that frequently individual members of society do not start their lives equally. This fact led social reformers in the nineteenth and twentieth century's to

advocate changes in working conditions, poor relief and public health. A huge literature was produced by social activists of the time, such as Henry Mayhem, linking inequality and poverty to disease and death (White 2001). Furthermore, contra the ethos of liberalism, John Maynard Keynes argued for a strong interventionist role for the state in regulating the market, protecting working and living conditions, as well as promoting public health. Adopting Keynesian economics to control the tendency of capitalism to operate in 'boom and bust' cycles formed an important part of the foundation of the post-second world war welfare state in the United Kingdom (Green 1987). However, large fluctuations in oil prices and economic recessions occurred in most western economies in the 1970s. This led to the labour government of 1976 devaluing the pound and seeking the support of the International Monetary Fund (IMF) (Graham and Clark 1986). The IMF provided credit and loan arrangements that in turn led to a political recognition of the need to introduce competitive practices into the workings of the welfare state. This eventually led to the privatisation of previously publicly owned industries such as electricity, rail and water (Cutler and Waine 1994). Concurrently, the ideas of a number of prominent 'liberalist' social commentators such as Friedrich Hayek (1973) and Milton Friedman (1962) - who both advocated a liberal market-based system instead of state-dominated welfare provision - became increasingly influential within the political arena. Particularly after the collapse of the Soviet Union. This led to Fukuyama (1992) arguing that the 'end of history' had occurred, and the only contender for legitimate government was now liberal democracy. Integral to which was the economic necessity of free-market capitalism.

The rise of the risk society

> "Each person's biography is removed from given determinations and placed in his or her own hands".
>
> Beck (1992: 135)

Whether they agreed with Fukuyama or not, these changes reinforced to sociologists that tied up with the political re-emergence of the 'enterprise culture' of liberalism was a renewed focus on the individual, particularly the idea that the individual alone possesses ultimate responsibility for herself, as the apparent gradual withdrawal of the state from welfare provision forces her "to make the transition from dependent, passive welfare consumer to an "enterprise self;" (Burchell 1996: 85). For the idea that an individual's life is her own enterprise may mean she has to submit herself to an endless process of self-examination, self-care and self-improvement. But it also means that she is now "free from the social forms of industrial society – class, stratification, family [and] gender status" (Beck 1992: 87). Her life is no longer mapped out for her. Who she is, and who she could possibly be, is no longer defined by her locality, her occupation, her gender, or even her religious affiliation. This does not mean that inequalities no longer exist. Only that they can no longer so easily attributed to the traditional sociological categories of class, race, age or gender (Beck 1992). So her identity is fluid and negotiable, detached from traditional social structures and cultural mores, she is able to reflexively construct her life biography as she sees fit. She is in a very real sense the creative artist of her life.

For risk theorists such as Beck (1992) and Giddens (1990 1991) a key defining feature of modern society – or 'late' or 'high modernity' as they call it - is that there has been "a social impetus towards individualisation of unprecedented scale and dynamism…[which]…forces people – for the sake of their survival - to make themselves the centre of their own life plans and conduct" (Beck and Beck-Gernsheim 2002: 31). In *Risk*

Society (1992) Beck argues that as capitalist-industrial society gives way under the tripartite forces of technology, consumerism and globalisation, there is a 'categorical shift' in the nature of social structures, and more importantly, the relationship between the individual and society. Furthermore, as working conditions change, and the technology and communication revolutions continue at pace, more than ever before individuals are required to make life-changing decisions concerning education, work, self-identify and personal relationships, in a world where traditional beliefs about social class, gender and the family are being overturned (Lupton 1999). This state of affairs leads to a concern with risk management entering centre stage within society's institutional governing apparatus, as well as individual subject-citizen's personal decision-making process (Mythen 2004).

Risk theorists argue that throughout human history society's have always sought to 'risk manage' threats, hazards and dangers. But these management activities have been concerned with natural risks, such as infectious diseases and famine. However, in today's technologically advanced society, individuals are seen to be both the producers and minimisers of risk (Giddens 1990). That is, within the conditions of high modernity, risks are by and large seen to be solely the result of human activity (Mythen 2004). Even events previously held to be natural disasters, such as floods and famine, are now held to be avoidable consequences of human activities that must be 'risk managed' (Lupton 1999). Hence society's institutions and expert bodies need to become ever more collectively self-aware of their role in the creation and management of risk (Beck and Beck-Gernsheim 2002). While for the individual uncertainties now litter their pathway through life to such an extent that it appears to be loaded with real and potential risks. So they must seek out and engage with on a seemingly ever-growing number of information resources, provided by a myriad of sources, as they navigate through their world. In the risk society "[we] find more and more

guidebooks and practical manuals to do with health, diet, appearance, exercise, lovemaking and many other things" (Giddens 1991: 218).

A key defining feature of the risk society is the demystification of science and technology, as well as a growing uncertainty about truth and claims to truth (Mythen 2004). Advances in communication technology - such as the mobile phone, the internet and the twenty-four hour news channel - have not just made individuals constantly aware of the risks associated with modern living, they also reinforce the limitations of technical and expert knowledge to cope with and even solve them (Lupton 1999). So much so that "attitudes of trust, as well as more pragmatic acceptance, scepticism, rejection and withdrawal, uneasily co-exist in the social space linking individual activities and expert systems. Lay attitudes towards science, technology and other esoteric forms of expertise, in the age of high modernity, express the same mixture of attitudes of reverence and reserve, approval and disquiet, enthusiasm and antipathy, which philosophers and social analysts (themselves experts of a sort) express in their writings" (Giddens 1991: 7).

Within the risk society, a sense of growing (perhaps even mutual) distrust characterises the relationship between the public and experts (Giddens 1999). At the same time, a pervasive and seemingly increasingly necessary reliance on an ever-growing number of experts appears to be a key feature of the individuals' personal experience of everyday life (Mythen 2004). Consequently, expert authority can no longer simply stand on the traditional basis of position and status. Not least of all because an individuals' growing need to manage risk and problem solve their everyday life, to make choices about who they are and what they should do, means that personal access to the technical and expert knowledge of the elite is now regarded as an inherent right. No longer the sole preserve of those elite few who have undergone specialist training. As Giddens (1991: 144-146) notes: "technical knowledge is continually re-appropriated by lay agents…Modern life is a complex affair and there are

many ‘filter back’ processes whereby technical knowledge, in one shape or another, is re-appropriated by lay persons and routinely applied in the course of their day-today activities…Processes of re-appropriation relate to all aspects of social life – for example, medical treatments, child rearing or sexual pleasure”.

Risk society theorists frequently observe that modern individuals increasingly find themselves having to make ‘risk laden’ choices “amid a profusion of reflexive resources: therapy and self-help manuals of all kinds, television programmes and magazine articles” (Giddens 1992: 20). In doing so, they echo the views of authors operating from a governmentality perspective (Lupton 1999). For both focus upon how in today’s society individual acts of self-surveillance and self-regulation are not only central to the formation of a person’s sense of personal identity, but also the management of risk at the individual and group levels, and therefore can be said to be a key mode by which the population is governed ‘at a distance’ without recourse to direct or oppressive intervention (Rose and Miller 1992).

Governmentality and ‘neo-liberal mentalities of rule’

> “Modern selves have become attached to the project of freedom, have come to live in terms of [that] identity, and to search for means to enhance that autonomy”.
>
> Rose (1990: 250)

A key point of difference between the governmentality and risk society perspectives lies in their conception of the individual-subject. For it is arguable that in spite of noting that an individual’s sense of self is now arguably more than ever before a product of her own making, risk society authors nevertheless seem to often stay wielded to the idea of the subject as an autonomous actor possessing a coherent core self (Elliott 2001). Consequently, they

often adopt a "positivist ego psychology, which is hostile to any notion that the self is complexly structured and differentiated" (Peterson 1997: 190).

Indeed, on occasion Giddens in particular seems to accept that the concept of the sovereign individual self lies at the heart of society to such a degree that he could be accused of being an uncritical apologist for liberalism's 'possessive individualism', and concurrent advocacy of a self-reliant 'enterprise culture', with its focus upon encouraging "autonomous, productive, individuals" (du Guy 1996a: 186). In contrast, following Foucault, governmentality theorists firmly historicise their conception of the individual by discursively locating it within the history of Western thought through critiquing the post-enlightenment conception of the rationally autonomous subject (Peters 2001). They advocate an alternative viewpoint whereby individual subjectivities are neither fixed nor stable, but rather are constituted in and through a spiral of power-knowledge discourses - generated by political objectives, institutional regimes and expert disciplines - whose primary aim is to produce governable individuals (Deleuze 1988).

Aside from this noticeable difference, the risk society and governmentality perspectives share much in common. Both argue 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 (Gordon 1996). For example, 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). Similarly, du Guy (1996a 1996b) argues that 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, he concludes, 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".

The risk society and governmentality perspectives both focus upon the changing relationship between individuals and experts during the last four decades. The re-emergence of liberalism in the 1970's re-activated classical liberalisms concern with the liberty of the individual, advocacy of free markets, and call for less direct government. It emphasised the entrepreneurial individual, endowed with freedom and autonomy as well as a self-reliant ability to care for herself, and furthermore, driven by the desire to optimise the worth of her own existence (Rose 1999). Governmentality theorists such as Rose (1993: 285) argue that this has led increasingly to the relocation of the authority of expertise from the political into the economic sphere where it is increasingly "governed by the rationalities of competition, accountability and consumer demand". Rose argues that during the nineteenth and twentieth centuries the increasingly rational, experimental and scientific basis of modern forms of expertise led to them becoming integral to the exercise of political authority. So much so that experts gained "the capacity to generate 'enclosures', relatively bounded locales or fields of judgement within which their authority [was] concentrated, intensified and rendered difficult to countermand" (Rose 1996: 50). However, as a result of the rise of the enterprise self, the enclosures are now being "penetrated by a range of new techniques for exercising critical scrutiny over authority – budget disciplines, accountancy and audit being the three most salient" (Rose 1996: 54).

Power (1997) and Rose (1999) emphasise the enormous impact of the trend in all spheres of contemporary social life towards audit in all its guises - with its economic concern with transparent accountability and standardisation - particularly for judging the activities of experts. This is because two technologies are central to the promotion of the enterprise self at the organisational and individual levels. A 'technology of agency', which seeks to promote the agency, liberty and choices of the individual as they strive for personal fulfilment, and a 'technology of performance', which seeks to minimise risk by setting norms, standards, benchmarks, performance indicators, quality controls and best practice standards, in order to survey, measure and render calculable the performance of individuals and organisational structures (Dean 1999). As Dean (1999:173) notes: "from the perspective of advanced liberal regimes of government, we witness the utilisation of two distinct, yet entwined technologies: technologies of agency, which seek to enhance and improve our capabilities for participation, agreement and action, and technologies of performance, in which these capabilities are made calculable and comparable so that they might be optimised. If the former allow the transmission of flows of information from the bottom, and the formation of more or less durable identities, agencies and wills, the later make possible the indirect regulation and surveillance of these entities. These two technologies are part of a strategy in which our moral and political conduct is put into play within systems of governmental purposes".

Bound up with the technologies of agency and performance of the enterprise culture, is what can be called a progressive and insipid process of 'contractualization' (Burchell 1993). Here, in a concerted effort to manage risk, institutional roles and social relations between individuals are increasingly defined in terms of explicit contract, or at the every least, 'in a contract like way' (du Guy 1996a). For the promotion of the enterprise form involves the creation of processes where subjects and their activities are "reconceptualised along economic lines" (Rose 1999: 141). Gordon (1991: 43) argues that entrepreneurial

forms of governance rely on contractualization as they seek "the progressive enlargement of the territory of economic theory by a series of redefinitions of its object". That is, entrepreneurial forms of governance 're-imagine' the social sphere as a form of economic activity by contractually a) reducing individual and institutional relationships, functions and activities to distinct units b) assigning clear standards and lines of accountability for the efficient performance of these units, and c) demanding individual actors assume active responsibility for meeting performance goals, primarily by using tools such as audit, performance appraisal and performance-related pay (du Guy 1996a). Here judgement and calculation are increasingly undertaken in economic cost-benefit terms, which gives rise to what Lyotard (1984: 46) terms "the performativity principle". Whereby the performances of individual subjects and organisations serve as measures of productivity or output, or displays of 'quality' and the ability to successfully minimise risk, so "an equation between wealth, efficacy and truth is thus established" (Lyotard 1984: 46).

Reforming medical governance

> "[Technologies of Performance]…subsume the substantive domains of expertise (of the doctor, the nurse, the social worker, the school principal, the professor) to new formal calculative regimes".
>
> Dean (1999: 169)

Osborne (1993) discusses how since the re-emergence of liberalism there has been a gradual reformulation of health care policy and practice, so that 'the field of medicine' is, to a greater degree than ever before, simultaneously both governed and self-governing. A key part of this process is the subjection of the activities of medical practitioners to an additional layer

of management and new formal 'calculative regimes' (Rose and Miller 1992). Such as performance indicators, competency frameworks and indicative budget targets (Rose 1993). This process began with the 1979 conservative administration, which possessed a firm neo-liberal commitment to 'rolling back the state' and introducing free market philosophies within the public and private spheres (Dean 1999). Thatcherism emphasized the entrepreneurial individual, endowed with freedom and autonomy, and a self-reliant ability to care for herself, and driven by the desire to optimise the worth of her own existence (Rose 1993). For example, the conservative home secretary Douglas Hurd stated in 1989 that "the idea of active citizenship is a necessary complement to that of the enterprise culture" (quoted in Barnett 1991: 9). A new form of citizenship was being promoted by the changing conditions caused by the re-emergence of liberalism and having a direct affect upon medical governance. Indeed, reviewing NHS reform during the mid-1990s, Johnson (1994: 149) noted that "government-initiated change has, in recent reforms, been securely linked with the political commitment to the "sovereign consumer". In the case of reform in the National Health Service, this translates…[to a] stress on prevention, the obligation to care for the self by adopting a healthy lifestyle, the commitment – shared with the new GP – to community care". This state of affairs did not end with the election of 'new labor' in 1997 (Dean 1999). Although generally critical of many of their conservative predecessors' health policies, under the guise of treating "patients as equal partners in the decision-making process" (Department of Health, 2000: 2), new labour introduced a comprehensive, management-led system of clinical governance into the NHS, designed to set and monitor standards governing health care delivery (Department of Health 1998).

Clinical governance is officially defined as "a framework through which the NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in

clinical care will flourish" (Department of Health 1998: 33). Clinical standards are set nationally by the National Institute for Clinical Excellence (NICE), which was established in 1999. This body makes recommendations on the cost effectiveness of specific treatments and disseminates clinical standards and guidelines, based upon evidence-based research, for compulsory use by doctors. It also plays a role in developing what are called National Service Frameworks (NSFs) which look at the pathways between primary (i.e. community based) to secondary (i.e. hospital based) care followed by certain patient types (i.e. those suffering from heart disease, diabetes or mental health issues) to identify activity levels and productivity figures and improve service resource allocation. The local implementation of the NSF guidelines and NICE clinical standards are monitored by what was first called the Commission for Health Improvement (also established in 1999) which has more recently been renamed the Commission for Healthcare Audit and Inspection (CHAI). CHAI is empowered to visit hospital and primary care trusts and ensure they are following good clinical governance guidelines. It awards star ratings, similar to those given to hotels, and likewise scores them based on their performance against set criteria, for example, length of time patients spend on a waiting list. CHAI is supported in its activities by the National Patient Safety Agency (NPSA), which was established in 2002 and focuses on promoting good health care practice.

Given new labour's reforms, it is unsurprising that in his review of NHS reform Light (1998: 431-2) stated that: "the national framework for performance management is extensive. The White Papers propose establishment of evidence-based patterns and levels of service, clinical guidelines, and clinical performance review, in order to ensure patients of high uniform quality throughout the service". Furthermore, Slater (2001: 874) believes that NHS reforms in general, and clinical governance in particular, have established "a rationalistic bureaucratic discourse of regulation which reveals itself through increasingly extensive rule

systems, the scientific measurement of objective standards, and the minimisation of the scope of human error. Behind it lies a faith in the efficacy of surveillance as a directive force in human affairs". This new rationalistic-bureaucratic discourse, with its focus on the surveillance and management of risk through standard setting and transparent performance monitoring, has presented a significant challenge to the authority of medical elites, such as the royal colleges and medical schools, who have traditionally been left alone to oversee the arrangements surrounding medical training and discipline (Stacey 2000). To ensure their continued 'fitness for purpose' medical elites have had to adapt and adopt more open, transparent and inclusive governing regimes, which furthermore rely upon a risk focused best-evidenced approach to medical governance (Lloyd-Bostock and Hutter 2008). This has required medicine's training programmes, disciplinary mechanisms and regulatory inspection regimes possess clear standards that can be operationalised into performance outcomes against which the 'fitness to practice' of members of the profession can be regularly checked in a transparent and accountable manner (Irvine 2003 2006).

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 2012). 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 2014). 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 (Chamberlain, 2012).

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). 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 naturally 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.

It is certainly the case that the introduction of revalidation has caused fear and anxiety amongst some quarters of the profession. However, no matter how long this process takes, medical elites have had to accept that the risk management of the activities of doctors will no longer is solely undertaken 'in house' by them alone (Stacey 2000). This in no small part is why the GMC and royal colleges are emphasizing the developmental, cyclical, nature, of revalidation. To some extent this state of affairs is to be expected as there is a somewhat natural tension between bureaucratic managerial systems of surveillance and control which seek to standardize working practices to make them measurable and predictable, and

professions such as medicine which emphasize practitioner autonomy in the form of freedom of judgment based around the possession of specialist knowledge and expertise alongside a recognition of the inherently messy nature of the real world of professional practice. But what is fundamentally different is that, more than ever before, there is inter-professional co-operation and managerial and lay involvement in the regulation of medical expertise (Chamberlain, 2014).

Liberal mentalities of rule and 'positive' and 'negative' liberty

> "[Under liberal mentalities of rule] a person's relation to all his or her activities, and indeed his or her self, is…given the ethos and structure of the enterprise form".
>
> Rose (1999: 138)

Policy developments such as revalidation reinforce the need to undertake a dedicated research programme into medical governance. It is widely acknowledged that such a programme is needed as their currently is a lack of published research on the topic (Gray and Harrison 2004). Yet sociologists need to keep in mind that current changes in medical governance take place against the background of a broader societal shift in the grounds under which the legitimate governance of the population can be practiced (Rose 1999). Governmentality theorists remind us that changes in how expertise operates are 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 1999). For changes in how good citizenship is practiced are bound up with shifts in the conditions under good governance operates. 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 (Rose 1996). 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

As was touched upon earlier, the concept of the self as enterprise requires that the possession of an essential core self is taken as the central feature of personal identity (Rose 1990 1993 1996 1999). How else could individuals be expected to become responsible for themselves and the care of their bodies and not be a burden on the state? The very notion of the enterprise self requires a political commitment to the idea that all individuals are capable of self-fulfilment. This is the core mechanism by which the self-regulatory capabilities of the individual can be enhanced and entwined with the key objectives of governance - the security, health, wealth and happiness of the general population (Barry, Osborne and Rose 1996). Consequently, failure to achieve the goal of self-fulfilment is not associated with the

possession of a false idea of what it means to be human, or that individuals do not possess an essential core self which is the 'real' and 'true' them for all eternity. Rather, it is the fault of poor choices, a lack of education or the 'dependency culture' created by the welfare state (Dean 1999). It is the result of 'learned helplessness', which in itself can be resolved with "programmes of empowerment to enable [the individual] to assume their rightful place as self-actualizing and demanding subjects of an "advanced" liberal democracy" (Rose 1996: 60). The sociological analysis of medicine and risk needs to focus upon this point as it considers the type of citizen and forms of subjectivity promoted and sustained by the governing regimes of the risk society (Peterson and Bunton 1997). For it is arguable that under the guise of advocating personal freedom and 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.

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