Analysis and comment

Professional regulation

The path to safer patients

Jonathan Gornall

Consultation on the chief medical officer's controversial proposals for revalidation and recertification of doctors ends next month. Many questions remain about their implementation

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In the summer of 2004, the General Medical Council's education committee ran an essay competition for 16-18 year olds, asking them to imagine what doctors might be doing by 2050. The judges, who included GMC president Professor Graeme Catto, were impressed by the many thoughtful musings about the effect of genetics, ethics, and even robot technology. Yet none of the bright young authors came close to predicting any of the upheavals that would be triggered by another "essay" that arrived on Catto's desk on 9 December that year—by chance, the same day the six winners were presented with their prizes.

The "essay" was the fifth report of the Shipman Inquiry. The inquiry's chair, Dame Janet Smith, found little in the GMC's past, present, or proposed future worthy of prizes.¹ Although she rejected "any suggestion that, even if the GMC procedures had been satisfactory, they could have prevented Shipman's later criminality," she thought that 30 years on from when Shipman had first come to the GMC's attention, it was still putting doctors first. What's more, she said, it had lost sight of its vision to reform. She declared the GMC's plans for revalidation, which it had been working on since 1988, "an expensive rubber-stamping exercise that would have misled the public," and the council was subsequently forced to put the plans on ice.

Fresh look at the problem

John Reid, then secretary of state for health, announced in January 2005 that the government had asked Professor Liam Donaldson, the English chief medical officer, to conduct a review to determine what action was necessary to "strengthen procedures for assuring the safety of patients in situations where a doctor's performance or conduct pose a risk; ensure the operation of an effective system of revalidation [and] modify the role, structure and functions of the GMC."

The result, *Good doctors, safer patients*, was published in July.² Because its 44 recommendations enshrine a belief within government and the upper echelons of the NHS that there is a widespread public loss of trust in the medical profession, many of them are certain to find their way into legislation after consultation closes on 10 November. In his report, Donaldson writes of "a series of highly publicised medical scandals, some to do with poor practice by individual doctors, others to do with local service failures in which patients were harmed [that] gave rise to mounting public concern." Yet even Donaldson concedes that estimating the scale of the problem of poorly performing doctors is a challenge, so much so that in his report he is obliged to draw on the results of a study he conducted while director of the Northern and Yorkshire Regional Health Authority during the early 1990s. This study reported that over five years, "serious concerns were raised in relation to the conduct or performance of 49 doctors [out of a total of 850], equating to a five year period prevalence of 6%".³ Poor attitude, commitment, or knowledge accounted for most of these cases.

The GMC, of course, has its own complaints statistics, but it is difficult to know what, if anything, they reveal about public trust in doctors. A decade ago the organisation received some 1200 inquiries, complaints, or referrals a year; by 2000 this figure had risen to 4500 and in 2005 it was 4980, up 12% on 2004. However, simply because more people are complaining does not mean that more doctors are deserving of complaint. In 2004, for instance, just 82 doctors were erased from the register—not bad, it could be said, for a population of more than 220 000 registered doctors.

If we took account only of the annual MORI polls conducted for the BMA between 1999 and 2005, we

Liam Donaldson and Janet Smith see eye to eye

would consider that all was well. Even in 2000, the first poll conducted after Shipman's conviction, the public ranked doctors as the most trustworthy in a league of 16 professions. But polls can be double edged. Donaldson's MORI poll showed that 78% of the public disagreed that there was no need to carry out checks on doctors simply because they trusted them.⁴ Worse, 84% either didn't know how frequently doctors were assessed or mistakenly believed that checks were carried out regularly.

Doctors' reactions

Nevertheless, many doctors will see Donaldson's proposals as an over-reaction to a ghastly but unique set of circumstances. As Dame Janet conceded, no amount of tinkering with the regulation of doctors will prevent another Shipman.¹ That matter, as James Johnson, chairman of the BMA Council, pointed out, has been addressed by Dame Janet's proposed reforms of the coronial system, death certification procedures, and drug monitoring.⁵ Johnson's fear was that the third aim of the inquiry—to ensure that “the good quality care provided by the large majority of doctors should have scope and opportunity for continued improvement”—would suffer in the rush to ensure the NHS was Shipman-proof.

Richard Smith, former *BMJ* editor, echoed Dame Janet's doubt that the GMC was capable of reform.⁶ His editorial led to a response from one consultant physician stating that it “paves the way for more political over-reaction to Dame Janet Smith's reports.”⁷ John Turner, of University Hospital Aintree, felt that an “unhealthy climate of fear has developed across a profession that is in danger of becoming de-professionalised—perhaps the political objective but surely not in the public interest.”

The political objective identified by Donaldson, however, is not to lessen the professionalism of medicine but to redefine that professionalism. This objective was identified as a political necessity by the Royal College of Physicians a year before the Donaldson report. In December 2005 a working party of the college offered a prescient glimpse of the post-Donaldson future, a future in which “securing trust is the most important purpose of medical professionalism.”⁸ To this end, they proposed a definition: “Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.”

As Donaldson noted approvingly in his report, “The working party rejected a number of the traditional dimensions of professionalism, such as mastery, privilege, autonomy and self-regulation. Instead, the report focuses on a model that puts the patient unequivocally first and is delivered through partnership with those patients and members of the wider healthcare team.”²

One of Richard Smith's criticisms of the GMC was that “whenever there is a trade-off to be made between protecting the public and being fair to doctors, the council has taken the side of doctors.”⁹ But is this true? The GMC, certainly, would reject the charge, as would every doctor who lives in fear of a letter from the regulator. As Patricia Hamilton, president of the Royal College of Paediatrics and Child Health, put it recently:

“Complaints made to the GMC result all too easily in lengthy processes during which doctors find their careers and lives blighted. We must be fair to complainants but we must be fair to doctors too.”⁹

In September the GMC took the extraordinary step of laying its cards on the table ahead of its formal response in an exclusive interview with its president in the *Times*.¹⁰ Many will have been surprised by the strength of Catto's apparent determination to do battle with Donaldson. The article quoted a draft GMC response in which the chief medical officer's proposals were said to “not be in the patients' best interests or contribute to effective and efficient regulation.” The recommendations, says the draft, “would amount to a dramatic fragmentation of regulatory responsibilities by separating responsibility for education, standards and fitness-to-practise adjudication from other regulatory functions. We consider this fragmentation to be unnecessary, unjustified and likely to cause profound damage to future patient care.”

GMC and revalidation

There are those, of course, who argue that the GMC has brought its troubles down on its own head (and, thus, on the heads of doctors). Mike Pringle, professor of general practice and coauthor of a paper outlining the original model for revalidation,¹¹ said the GMC had “precipitated a crisis by diluting its proposals for revalidation and then responding intransigently to the fifth Shipman report.”¹²

It wasn't as if the GMC hadn't had time to consider revalidation. The topic was first aired in 1975, when the Merrison report tabled the idea of linking registration with frequent tests of competence. In his 2003 book,¹³ Sir Donald Irvine, past president of the GMC, recalled that by 1998 awareness was growing within the GMC of “the clear public expectation that medical regulation should include measures to assure patients that consultants, and general practitioners, continue to perform effectively throughout their working lives.”

One version of what happened next was that somewhere along the way the GMC's best intentions were hijacked by intransigent vested interests. Irvine, who stood down six months early after having presided over some of the most controversial episodes in the council's history, later claimed council members were “minimalists who still hankered after the old style of medicine... to do the least possible consistent with good appearances.”¹³ But according to Alexander Macara, chairman of the BMA Council between 1993 and 1998, there was more to the story. In a letter to the *BMJ* early in 2005 he recalled that in 1994 the BMA had organised a conference, attended by royal colleges, deans, and the GMC, that addressed various challenges facing the profession, including performance review procedures.¹⁴ Discussions led to *Self-regulation and clinical governance at local and national levels*, signed by the chairs of all the leading medical organisations and presented to the government in July 1998.¹⁵ The document committed the professional bodies to work together to “solve problems at an early stage and at a local level.”

The pre-echo of Donaldson is loud and clear. Macara believed that, had the plan been pursued, “much if not all the trauma of the past six years could

Donald Irvine (former president of the GMC) and Graham Catto (present president) presided over different conceptions of revalidation

have been avoided.”¹⁴ Yet, “within days of its release a number of the co-signatories, myself included, had demitted office and Sir Donald Irvine, as president of the GMC, had produced his revalidation proposals. It is difficult to resist concluding that shifting the focus to these proposals (now seen to be flawed) distracted the profession as a whole from the more promising combined operation on which it had embarked.”¹⁴

After a special GMC conference in February 1999 a revalidation steering group was formed and tasked to produce proposals for implementation by 2002. Had that target been hit, Donaldson’s report might have been a lot shorter, or even unnecessary. By April 2003, however, the GMC’s plans had changed. According to Dame Janet: “Not only had the GMC rejected the idea that revalidation should, for most doctors, be based on evaluation by local revalidation groups, it had also moved to a position where . . . ‘five satisfactory appraisals equals revalidation’.”

Three months later, Pringle wrote that revalidation as it was now envisaged would create only an “illusion” of protection from poor doctors.¹ Dame Janet and Donaldson agree.

Cost of failure

Whoever was to blame for the failure of the GMC to deliver sufficiently extensive reforms when it had the chance, it is doctors who now face more years of trauma. The changes will increase the burden of bureaucracy and double the cost of regulation from £77.7m (£116m; \$145m) to an estimated £155.9m—an increase that doctors will almost certainly be asked to share to the tune of some £18m.¹⁶

Ministers seem to consider that the proposals in *Good Doctors, Safer Patients* constitute a well considered, workable package that meets all of the government’s concerns. Patricia Hewitt, the health secretary, said in July that Donaldson “has rightly thought to balance the need to ensure the highest quality of patient safety with the concerns of the medical profession.”

Some people in the medical profession, however, might be more inclined to side with the view of Mike Harmer, outgoing president of the Association of Anaesthetists of Great Britain and Northern Ireland. In

his valedictory report to his members in September,¹⁷ he wrote: “One can see that the changes proposed in this report are designed to help boost public confidence in the regulatory body, but . . . there is a lot more bad news for doctors than good news and even the best doctor will have to jump through even more hoops.”¹⁷

Role of appraisal

Professor Donaldson’s position on appraisal—the building block of revalidation as envisaged by the GMC—seems to have altered somewhat. The GMC worked closely with the Department of Health in developing its revalidation model, and the government supported the GMC’s consultation paper, published in June 2000. As Dame Janet concluded from a letter Donaldson wrote to her in November 2004, “the proposals for revalidation . . . now appear to be the joint proposals of the GMC and the DoH”. At this stage, wrote Donaldson, appraisal of NHS doctors “is now well established.” Dame Janet was not convinced: “It appears from the CMO’s letter to me that he is satisfied that appraisal is already an adequate foundation upon which to base revalidation. I regret to say that I cannot agree.”

In his current report, Donaldson now says appraisal “is very patchy and lacks rigour.”² But whatever his views in 2004, he has now proposed that a currently unknown independent organisation should be charged with designing and administering a “360-degree feedback exercise required for appraisal and licence renewal.” This is another proposal that has raised eyebrows at the GMC, which since October 2005 has been working on developing just such an instrument with a team from the Peninsula Medical School.¹⁸ The results are due to be presented in December.

Donaldson wants revalidation to have two components: the renewal of a licence to practise and, for those doctors on the specialist or general practice registers, recertification. “The emphasis in both elements,” says Donaldson, “should be a positive affirmation of the doctor’s entitlement to practise, not simply the apparent absence of concerns.”²

Although relicensing would be based on the (new, to be improved) NHS system of appraisal and “any concerns known to the GMC affiliate,” recertification would be a job for the royal colleges. Specialist certification, which would be renewed at least every five years, “should rely upon membership of, or association with, the relevant medical Royal College, and renewal should be based upon a comprehensive assessment against the standards set by that college.”²

Certainly, although they are still formulating their responses, every indication is that the royal colleges would embrace this new role. However, the GMC’s annual tracking polls show individual doctors are, on the whole, less in favour of some form of revalidation this year than they were last. In August 2005, 52% of 1761 doctors supported revalidation, while 21% opposed it. By April-May this year, however, support had dropped off to 42% and opposition had increased to 28%.

Donaldson compared regulation in medicine with governance in other industries in which safety is critical and commissioned a study by the Industrial Psychology Research Centre at the University of Aberdeen.¹⁹ This looked at the aviation, nuclear power, and offshore oil industries and led Donaldson to observe that: “At

present, a senior doctor can go through a 30-year career without undergoing a single assessment of their fitness to practise, whereas an airline pilot, meanwhile, would face over 100 checks over a similar timescale.”²⁰

What the study didn't take account of, however, was pilots' working hours.²¹ With many of the UK's 39 000 junior doctors still working illegally long hours²² the dangers for patients are obvious yet the remedy is not more reforms but mere compliance with existing law.

New court for doctors

If the carrot for doctors in Donaldson's proposals is a commitment to “a diminution in the adversarial flavour of fitness to practise procedures,” then the stick is found in plans to introduce a new adjudicating body operating to a lower standard of proof. Many doctors will agree with the chairman of the BMA Council that the proposed introduction of new tribunals to “try” doctors, operating to a lowered standard of proof, “opens the door to miscarriages of justice, which will devastate the lives of doctors and their families.”²³ Critics (and the GMC) may say that the new streamlined fitness to practise systems have been allowed too little time to bed down and prove their worth, but Dame Janet decided that “some of the defects of the old procedures had been remedied but that, in other important respects, the old shortcomings were to be perpetuated. I also found that some changes had been retrograde.”

As with revalidation, the GMC had been edging towards a solution that might have satisfied Dame Janet but had backed away. It had originally considered hiving off the adjudication stage altogether, but the solution adopted in November 2004 was a compromise that kept adjudication and investigation in-house, with the GMC, as Dame Janet noted, “intending to introduce a measure of separation by using only non-members of the GMC for its adjudication stage casework.”¹

That, said Dame Janet, would never do, and Donaldson agrees. In the interests of transparency, he wants to see investigation and assessment carried out by the GMC but adjudication undertaken “by a separate and independent tribunal with legal, medical and lay representation”.

This is certain to be one of the grounds on which the GMC plans to stand and fight. “What is this new body?” asked Catto, firing a calculated warning shot in his interview in the *Times*.¹⁰ “To whom is it responsible? Who is its paymaster?” It was, he said, difficult to see how doctors could have confidence in such an organisation.

Doctors will find it even harder to have confidence in the new “court” if it operates to the civil, rather than criminal, standard of proof. “Medical jurisdiction,” says Donaldson, “is a protective jurisdiction and the civil standard should apply. This will reduce the number of cases where a doctor is not judged ‘bad enough’ to enter formal GMC procedures but is still a cause of serious concern.”²

In this fight, the GMC is likely to find an ally in the BMA, which has said doctors would be “hugely critical” of the proposal to lower the standard of proof. “No one wants to put people at risk by bad practice,” said Johnson. “But it seems wrong to be able to take away a doctor's livelihood because of something found on a balance of probability.”

Affiliate or informant?

One of Donaldson's most controversial (and expensive) proposals is for a network of around 580 trained and accredited GMC affiliates. Affiliates would be “clinicians of high standing, having credibility with, and the support of, doctors, managers and patients” who would take on at a local level the GMC's “role in investigating concerns or complaints about a doctor's standards of care or conduct.”² Donaldson believes it is important that this role is carried out by a local clinician in active practice. Setting aside the question of exactly how much spare time such popular, active clinicians might have, it is not clear how eager most doctors would be to take on such a role—categorised in one newspaper report as that of a “nark.”²⁴ For Donaldson, however, the role of affiliate “should be seen as both a professional duty and a mark of distinction . . . Its prestige and importance should be reflected in reward schemes for doctors.”

The BMA thinks the proposal “would place a huge responsibility on one person [and] will be one of the most difficult recommendations to implement.” The royal colleges are still formulating their reactions, but a viewpoint in the *Journal of the Royal College of General Practitioners* queries whether the role of affiliate adds anything to existing arrangements, whereby in general practice primary care trusts handle any “cause for concern.”²⁵ The author adds: “It is hard to believe that GPs or consultants will apply for a position which seems professionally isolated and more like performance manager than senior statesman.”

Curiously, Donaldson's 1994 paper³ indirectly provides some evidence that the old professionalism based system of peer control might be more efficient than portrayed and that the invention of the affiliate might be a cosmetic and expensive reinvention of a wheel that is already turning efficiently. All 46 doctors about whom concerns were raised during the five years of his study were reported by colleagues.

Certainly, the work burden for each affiliate would be considerable and some are bound to question the logic of taking accomplished clinicians out of the front line to occupy such a bureaucratic role (not to mention the cost: Donaldson estimates the salary bill for the envisaged 580 affiliates and teams, comprising a lay adviser and administrative staff, at £30m a year, but says nothing about the cost of replacing the lost clinical hours of doctors who will be “on average 0.3 WTE [work time equivalent] Senior Clinicians”¹⁶). Such affiliates would be able to decide some fitness to practise cases locally and would be saddled with the responsibility of blighting a colleague's career by introducing a “recorded concern” (and any doctor who refused to accept such a “recommendation” would be automatically referred to the GMC).

Another chore for the affiliate would be to submit regular returns to a new central, national committee tasked with reviewing all such “recorded concerns.” As well as introducing yet another new body to the panoply of NHS organisations, this also introduces yet another jeopardy for doctors, as Donaldson would like to see this committee empowered to refer a practitioner to the GMC for further investigation.

It would be the responsibility of each healthcare organisation to alert the GMC affiliate to complaints

that raised concerns about specific doctors. Affiliates would also be expected to meet with complainants and would have the authority to order doctors to attend such “resolution meetings.” These, says Donaldson, “will reassure the public and complainants that their concerns have been heard by the medical regulator, will facilitate a dialogue with complainants, and will enable the complainant to learn what action is being taken to prevent similar problems in the future. The meeting will also provide a forum for an apology to be made, where this is appropriate.”⁷² It comes as little surprise that Donaldson wants affiliates to operate as one half of a double act “with a member of the public, who should be trained in regulatory and disciplinary procedures”.

The burden of training and auditing affiliates would fall to the GMC. What isn’t clear from his report is how Donaldson plans to select his “lay affiliates” and whether such a process would be sufficiently robust to satisfy doctors who already suspect, in the words of John Turner, a consultant physician at University Hospital Aintree, that the GMC’s current lay members are “selected for their anti-doctor sentiment by an anti-doctor government administration.”⁷⁷

Affiliates would shadow a doctor from training through to retirement. As they approached the end of their careers, doctors would be “invited to a review with their GMC affiliate, where registrant and affiliate should decide together whether a further five-year period of re-licensure is desirable and appropriate.” In another bold step, Donaldson wants to see medical students awarded registration with the GMC and then subjected to the same system of GMC affiliate overview. This, he says, “will ensure that performance, health and conduct problems amongst medical students are identified and addressed at an early stage in their careers.”

This echoes Dame Janet’s thinking precisely. Turner also wrote of his fears that doctors increasingly faced “a test of attitude rather than competence, with draconian suspensions of caring clinicians for being ‘off message’ with a Department of Health tainted with government spin.” If those fears appeared extreme in January 2005, they now appear less so. Speaking at the GMC’s education conference in May 2005, Dame Janet set her sights firmly on the question of attitude among medical students: “That may sound harsh but . . . It would be useful and sensible to have some means of weeding out and failing students who have not managed to catch on to and absorb essential ethical principles which they will be expected to practise throughout their career.”

End to self regulation?

Although the GMC has only recently reformed its own structure and governance, reducing its overall size to 35 members and increasing the proportion of appointed lay representatives, Donaldson clearly regards the efforts as too little, too late. All GMC members, he says, should be appointed, not elected. This, he says, will “remove the concept of members having constituencies to represent [and] will also reduce any perception of professional protectionism.” Currently there are 19 elected doctors on the GMC (plus two doctors appointed by educational bodies) and 14 lay members.

It is unclear how many appointees in future will be doctors, but Donaldson’s proposed restructuring will

almost certainly have the effect of removing the BMA’s influence over the GMC. That, it seems, is one objective the GMC shares with Donaldson. In an interview with the *Financial Times*,²⁶ Catto signalled that the GMC was ready to end the automatic majority on the council for medical professionals. “Professionally led regulation suggests that doctors lead and others follow,” he said. “That is no longer a helpful description . . . the public generally are far more sceptical and much less deferential to people in authority. They are much more likely to accept decisions if they have a share in making them.”

The BMA, however, is unlikely to take this lying down. Laurence Buckman, chairman of the GMC committee for the BMA, told the *Financial Times*: “We would regard this as the end of professional self-regulation, and that would be completely unacceptable.”

Education

The GMC is particularly exercised over Donaldson’s plans to take away its role in setting the content of the undergraduate curriculum and inspecting and approving medical schools, and to hand both tasks to the recently formed Postgraduate Medical Education and Training Board. For Donaldson, the proposed change “will enable the approach to curricula, standards and inspection in medical education from undergraduate through to postgraduate to be addressed more seamlessly than at present.” The GMC, however, is adamant that this would not be in the best interests of patients.

“The public have a right to expect good doctors, which means that they must be up to date and fit to practise throughout their working lives,” said Catto in the GMC’s first public response to Donaldson.²⁷ “That in turn means that medical education must be linked to our other functions, including registration and revalidation. The UK is, rightly, recognised as a world leader in medical education. The case for change has not been made.”

Much of the GMC’s work in medical education has been at the cutting edge—and much has been aimed at the same targets that Donaldson seems to be trying to hit anew. Raymond Tallis, the doctor, writer and philosopher, points out that “poor communication” is the most common complaint levelled at doctors, and that this complaint “touches on many other discontents: the paternalistic attitudes of ‘god-like’ doctors, time pressures and the question of ‘trust’.”²⁸

Concern about this was one of the driving forces behind *Tomorrow’s Doctors*, the guidelines for medical schools first issued by the GMC in 1993, as a result of which medical students are now “taught how to perform the role of a good—listening, empathetic—doctor.” For the GMC, the document signalled “a significant change in the form of our guidance. Our emphasis moved from gaining knowledge to a learning process that includes the ability to evaluate data as well as to develop skills to interact with patients and colleagues.”

It’s a mission statement that could have come straight from the Donaldson report. Indeed, when it came to recognising the primacy of the patient in the doctor-patient relationship, the GMC was way ahead of

Donaldson and Dame Janet. The social commentator Polly Toynbee, writing about the updated *Tomorrow's Doctors* in 2002, described it as "an idealistic compendium of the very best qualities every new doctor should acquire."²⁹ She was, however, incredulous at the "perverse" order of priorities that seemed to value "touchy-feely, modish" qualities over a basic ability to make sick patients well.

Today, says Tallis, "Avuncular, kindly doctors ... are more likely to get away with technically poor medicine than a brusque, technically competent doctor will get away with failing to show he cares. The process often weighs more in patients' judgment of their care than the outcome."

It would be tragic if some of the lessons of the Shipman disaster were lost in the rush to "Shipman-proof" the medical profession. Cosmetic appearances can be deceiving and, though it might be a heresy to say so, patients don't always know what's best for them. Tallis recalls the poignant remark from the son of one of Shipman's victims: "I remember the time Dr Shipman gave to my dad. He would come round at the drop of a hat. He was a marvellous GP."³⁰

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Never mind the gym, do medicine

I have just completed my first foundation year as a doctor in a large busy district general hospital. Not being one for physical exertion, preferring golf and snooker to anything more strenuous, I nevertheless find myself fitter than ever. Why you ask? Well, working for a living is rather hectic: several ward rounds a week, plus on-call duties and post-take rounds, and not forgetting the frantic running from patient to patient in between the rounds.

The distance that junior doctors cover on foot is not a new phenomenon, being recognised by Jones and Hughes as "additional duty miles" (*BMJ* 1996;312:1542). However, they studied a 24 hour period while on call. I conducted a study over 12 days using a pedometer, which records the number of steps taken and translates them into the distance covered. This approximately correlated with an average distance of 9 km on a "normal" day and 11-13 km on an on-call day. The repercussions of such high mileage were revealed when I discussed the results with a fellow foundation doctor, who admitted that she had destroyed no less than seven pairs of shoes during her F1 year.

The results reminded me of an observation made to me when I was a medical student, one that I now recognise as fact. Medical students walk at a leisurely, if not sluggish, pace. House officers walk faster, more

purposefully. Senior house officers walk faster still, with house officers barely keeping up. However, specialist registrars are the fastest things on two legs, leaving everything else standing, if not quaking, in their wake. For consultants, the rate of knots seems to decline, and their stride is calm, cool, and composed.

One thing is for certain, I will not be joining any gym in the New Year, but I will be investing in some decent sports shoes. I can't wait for those consultant years, if indeed my stamina lasts that long. Maybe the only way to endure the gruelling years of forced marches ahead would be to ensure regular servicing, say every 3000 km?

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We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com>. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.