The future of the GMC: an interview with Donald Irvine, the new president

Richard Smith

Donald Irvine is the first general practitioner to be elected president of the General Medical Council (GMC). Richard Smith spoke to him half an hour after he completed his last ever surgery at his practice in Ashington, Northumberland.

RS: What are the key problems facing the GMC at the moment?

DI: The first is getting its image and its relationship right with the outside world. It must be seen to be interested in good practice and to be connecting with patients' concerns. It shouldn't be seen just as a punitive body that does or doesn't work depending on your point of view.

RS: Is it seen largely as a punitive body?

DI: Many doctors don't know what the GMC actually does. It's just something in London to be avoided at all costs.

The importance of "Good Medical Practice"

RS: Do you think that you might change that?

DI: The council has been tending to emphasise the positive side of practice in the past few years. This changing attitude led to the standards committee producing *Good Medical Practice*, which was approved by the council last week.¹ It's a major reorientation. [*Good Medical Practice* lays down the essential skills, behaviours, and attitudes that constitute good practice. Sir Donald, as chairman of the standards committee of the GMC, played a central part in its creation.]

RS: Because it's positive rather than just negative?

DI: It's more than that. It makes explicit the link with registration, which gives doctors privileges and benefits, including the right to earn their living as doctors. But it's also a privilege to be associated with a profession that is held in such high esteem by the British public. In many parts of the world the grasping image of doctors has taken over from the caring image.

The GMC shouldn't be seen just as a punitive body

The flipside of the privileges and benefits is that there are duties and responsibilities that go with registration—and that is what is set out in our statement on good practice. We want doctors to realise that the GMC is the custodian of good standards and therefore protects the good name of our profession.

RS: But how can you change a century old view of the GMC as a punitive body to be avoided?

DI: We must help doctors understand its broader constituency, particularly with the public—because its primary regulatory function is to protect the public. And we need to engage more with the public and help them understand, for instance, that the GMC is different from the BMA.

RS: But what mechanisms can you use to achieve that end—newsletters, videos, conferences, what?

"Self regulation provides much more motivation than putting things into people's contracts and saying that you will do this or that . . ."

DI: All these and more. There is no single way. We need to develop a five year strategy for getting the message over. For instance, when the booklets on good practice are published we must make sure that they come out in an attractive, readable form. We need to talk to doctors and patients and listen to what they say. We also need a completely fresh approach with medical schools. I hope that within three months of joining a medical school every student will know about the GMC and the importance of acquiring the skills and attitudes that the profession, through the council, thinks are associated with good medical practice. I hope that the medical teaching establishment will embrace that. Many do already. Nobody should qualify in medicine without a clear idea of what he or she is signing up to.

RS: And what about the public?

DI: Instead of being reactive and waiting for people to come to us, we must reach out to them. For instance, Robert Kilpatrick [the current president] has talked to many people about the new performance procedures. One result of his efforts is that our links with parliamentarians are better than they have ever been. But we need to go out to consumer bodies, the Patients' Association, and a whole range of public organisations—many of which, given half a chance, would like to help the medical profession. The public should become our champions.

RS: So you want to turn the GMC from a reactive to a strategic body?

DI: Yes. It needs to be able to think ahead more so that we try not to be taken by surprise.

BMJ, London WC1H 9JR
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BMJ 1995;310:1515-8

Working with other medical bodies

rs: What about working more with the other medical organisations—like the colleges and the BMA. Is there room for change there?

Dr: There's scope for a harmonious relationship in which each body gets on with what it is responsible for to the best of its ability. But there's also scope for trying to work together so that the profession and health care can move forward constructively. Everything will not be hunky dory all the time. There will be differences, but I would like us to look for agreement on the highest common factor in the ideals we share.

The public should become our champions

rs: Do you think that there's any room for the kind of high level political forum that brings these organisations together in the way, for instance, that Sir Maurice Shock [former chairman of the Committee of Vice Chancellors and Principals] has suggested?²

Dr: There is a place for some kind of forum through which we can communicate with the outside world about the academic and scientific aspects of medicine and about ethics and values—something like an academy of medicine.

rs: But what about the high political body?

Dr: That wouldn't be so easy to accomplish. Anyway we have bodies—like the BMA—that handle the politics already. There is something to be said for keeping some functions separate. The GMC deals with standards and regulations. Nobody doubts that the BMA represents doctors and their interests; that the royal colleges and faculties are about postgraduate training and continuing medical education; and that the universities are there to prepare medical students for the profession and to be the major motor for research in medicine.

rs: But sometimes those bodies say different things, which confuses the public.

Dr: Finding some mechanism—and I have no prescription—for drawing the elements together must be a good thing. The recent BMA initiative on core values was a good example³; and the liaison established through that will continue and could do good things.

The importance of self regulation

rs: Why does self regulation matter?

Dr: It's tied up with self respect and most powerfully with our sense of professionalism. In a subject as complicated as modern medicine—where each doctor has to integrate as best as he or she can the best of science and caring into every clinical decision—you rely on that practitioner's motivation to get it right. Patients rely on that. Self regulation—being responsible, collectively and individually, for our own standards—helps to provide that motivation.

rs: Is self regulation under threat?

Dr: Only if we let it go by default. Self regulation provides much more motivation than putting things into people's contracts and saying that you will do this or that. But we can't fudge the fact if people behave or perform badly. Self regulation in any system—be it medicine or parliament—is built on trust. And if a gap grows between those who are regulating themselves and the public they serve—that's when the threat to self regulation comes. Think of parliament and the Nolan committee.

... But we can't fudge the fact that if people behave badly we have to act firmly."

What the public says of the medical profession at the moment is that we are not good at handling our poorly performing doctors. So we are signalling very clearly that we are doing something about that. It's our duty not only to promote good practice but to protect people from bad practice.

The GMC and changes in the NHS

rs: One of the reasons why doctors might see the GMC as irrelevant is that they are demoralised by the changes in the health service, yet they don't hear the GMC saying anything about that.

Dr: I agree that many doctors feel that way. One of the things about *Good Medical Practice* is that it makes explicit for the first time what good practice is—what our principles, attitudes, and values are. I think that when doctors identify with those statements then the GMC ought to be able to champion the doctors' cause with the public. Through that I think we might be able to promote confidence within the profession. But equally the GMC should help the public understand what doctors are about, what they can do and, as importantly, what they cannot. In a world where so much is changing so fast, we might then be able to bring about some peace and tranquillity for the profession.

rs: But could the GMC make more explicit statements about the state of the NHS?

Dr: The strength of the GMC is its independence as a standard setting body. It should make clear what, ideally, the standards should be. It should not compromise its independence by getting mixed up with the detailed politics of implementation. There is always a compromise to be made between what is ideal and what is feasible. If you fuse the pursuit of the ideal and the means to achieve it into one process then the danger is you can't see the join. You could then settle for what is less than optimum and kid yourself and the outside world that this is what you actually wanted to achieve.

The public says . . . that we are not good at handling our poorly performing doctors

If you keep responsibility for standard setting and provision separate then you can identify the gap between the ideal and present circumstances and so show clearly what else is needed.

The preregistration year

rs: You have said that you want to work on the preregistration year particularly. Why?

Dr: It's the one part of postgraduate training that is under the direct control of the GMC, together with the universities. Over the years the growing pressures of service have progressively squeezed out the educational nature of the year. Yet the year is still part of the process of joining the profession, of preparing for the independent practice that follows registration. If you listen to young people they won't say that the preregistration year is an enjoyable experience in which they can round off their education with some practical experience of patients. We could make it a smashing period for young doctors in which the senior members of the profession show what good teachers they really are. They could set an example for the later years of training. As it is, senior house officers, the "lost tribe," too often complain that they aren't taught,

"I'm in one of the few practices in the country that has been through the process of retraining a doctor who was suspended on competence grounds by the GMC."

that their teachers aren't interested, and that their teachers aren't good at teaching.

My experience of general practice training tells me that the preregistration year doesn't have to be like that. General practitioners have managed a proper balance between experiential learning with patients and the academic part. Somewhere in there lies the possibility of significant improvement for the preregistration year.

RS: But there's a feeling about the GMC that it often says the right things about medical education but is not effective at implementing them.

DR: That's a fair point. We tend to go at a leisurely pace. We have to demonstrate that if we make recommendations people find acceptable then they have to be implemented. That's why I've given a target date for improving the preregistration year of three years. We must have something to aim at rather than a nebulous feeling that we'll get there eventually. With the universities we must define what is necessary and let the outside world judge us by our ability to get there.

Performance review

RS: You've said that everybody wants a mechanism for the profession to deal with poorly performing doctors, and proposals are now making their way through parliament. But there are problems. For instance, how many poorly performing doctors are there?

DR: I don't know, although many estimates have been made. One way to make an estimate is to extrapolate from the cases flowing through the conduct machinery, but that, I think, produces an underestimate. There are health authorities and trusts who have real difficulties now with poorly performing doctors and don't know what to do because there is no proper machinery to deal with them.

RS: But is it tens, hundreds, or thousands?

DR: It's certainly in the hundreds. There is likely to be an iceberg effect.

RS: And is the GMC going to be good at engaging with these doctors? If you draw an analogy with sick doctors the GMC doesn't seem to have engaged with most of those.

DR: Let me step back and go back to the linkage with good practice. The main object has to be to prevent doctors from performing poorly, from putting their patients and themselves at risk. The council's main job is therefore to relate to the bulk of the profession who are doing a good job and to make sure that everybody feels that they can continue to do so. It's a failure on our part, as a profession, if people fall behind and start to put patients at risk.

We are then into the methods of how you assess performance, and that work has started. But it's going to be 18 months to two years before the machinery becomes operational. We have to agree assessment methods with all the major specialties and then consider retraining.

RS: My experience with retraining and reorienting people who go off the rails is that it can be extremely difficult, expensive, and time consuming. It's not just a matter of a few week's education. Isn't it very difficult?

DR: I agree that it is difficult. The retraining exercise could potentially be very large indeed. But as a matter of principle I think that people must be given the chance. We'll find some doctors who are well motivated. They will learn new knowledge and skills. The difficulty will be with doctors who do not recognise that they have a problem or who just say no to retraining. They may find that they cannot practise

in future if their negative attitude puts patients at risk.

RS: But if you accept that retraining can be difficult and prolonged the corollary is that it's expensive. So won't NHS employers be likely to say "It's a lot easier for us to get rid of this person and employ someone younger who doesn't have these problems"?

DR: I'm in one of the few general practices—if not the only practice—in the country that has been through the process of retraining a doctor referred by the GMC. We got the health service to pay his salary for a year as a trainee even though he had been in practice for 20 odd years. It's been a very valuable experience to know first hand what it's like.

He was well motivated. Yet he had been isolated. One of the things we found on bringing him from a single handed to a teaching practice was his enormous sense of relief—of being alongside people who would support and help him. Videotaped consultations were the key to his rehabilitation—helping him improve his consulting skills. I give full marks to my partners—because it wasn't me—who helped him get better. He's now been back in a group practice, and he's happy and safe.

The GMC could have said "Go and see the postgraduate dean about doing some courses," but that wouldn't have helped in this case. With the poorly performing doctor we have to make an accurate diagnosis and use the full range of educational treatments available: the precise diagnosis and treatment chosen will vary from one doctor to another.

It seems right to me in principle that we protect patients by removing unsafe doctors from practice or by restricting their practice. They then have to have the chance to recover their competence. The chance can't go on for ever, but to have a chance seems only right and fair.

RS: But isn't there a danger that employers won't pay?

DR: I look to the BMA to join the GMC in putting the case firmly to government that it's the responsibility of a major employer like the health service not only to support the professional development of all its staff but to support retraining when necessary. That's what being a good employer is all about.

RS: Let's put it this way: if at the end of the day the government or the NHS won't pick up the tab should the profession pick it up itself?

DR: There is a strong argument that doctors who need retraining should contribute. I agree with that. But there is also the argument that says an employer has some responsibility: how did the employer let a doctor get into that condition in the first place?

RS: I was meaning not individual doctors but the whole profession.

DR: The profession will be paying for the assessment and for the reassessment at the end of any training through the GMC retention fee. And that's right because it has to do with standards and self regulation. But for the vast bulk of doctors in the NHS the retraining should be funded within the NHS. And it's for the BMA to make sure that this happens—it's to do with terms and conditions of service.

Organisation and business of the GMC

RS: You talked in your election proposals about reforming the processes of the GMC. What are the priorities?

DR: We must be accessible and see the profession and the public as people we serve. We must be less bureaucratic and more welcoming.

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A lot of the GMC is in little boxes—education, standards, fitness to practise—and we need to function more as a whole. In particular, I'm keen for us to look outwards and forwards. We must see what is going on in health care and constantly refresh ourselves. We must listen, be more modern, make full use of new technology. We can learn a lot from others. There is a world outside medicine that can enrich medicine.

RS: Radical change can be difficult to achieve in an organisation that has been going along a particular track for a century.

We must be less bureaucratic and more welcoming

DI: Yes, but it's not just me that wants to change. The council and the staff do as well. We start with the golden asset that people want to move on.

RS: What about the size of the council?

DI: It's very large, and that is a problem. But it's come to this through the need to satisfy a lot of different constituencies. We can do a lot to make it more enjoyable and productive. We have a lot of talent on the council, and going to two meetings a year is not the only way to contribute.

RS: What about getting more people to vote in the election?

DI: We have this debate after each election for the council, and one view is that a relatively low turnout is common in most professional organisations. People don't vote if they think that things are going reasonably well or if the election doesn't touch their lives. When *Good Medical Practice* comes in and the performance procedures begin to work I think that more doctors may see the GMC as touching their lives and more may vote in future.

The relevance of general practice to running the GMC

RS: What special skills do you bring to the GMC?

DI: Ones that stem from my experience in general practice. I'm a patient centred person. I believe in the renegotiation of the balance of power between doctors and patients—and I think that both will emerge from that negotiation happier.

I've also had a lot of experience in general practice education, and I think that people in most specialties now recognise that general practice education has something special to offer medicine. It's to do with being clear what the educational objectives are, enthusing teachers to be good teachers (and helping them get there), and making the learning experience as vital and interesting as possible. I can bring those experiences to the educational debate. Using those principles is the way to transform the preregistration year.

RS: Being president of the GMC seems now—and perhaps it's always been so—to be a very political job. Are you a political animal?

DI: I think I'm fairly streetwise. But to succeed you have to have some ideals and a good sense of direction of where you and others want to go. Then the politics follow. I couldn't rely on streetwisdom alone.

RS: You finished your last surgery half an hour ago. How do you feel about that?

DI: It's been an extraordinary week. One day I'm elected president of the GMC, the next I leave 35 years of not only my own practice but also my father's practice. But I'm leaving a happy practice. Patients seem to like it and people like to work here. I'd like that for the GMC.

1 General Medical Council. *Good Medical Practice*. London: GMC, 1995.

2 Shock M. Medicine at the centre of the nation's affairs. *BMJ* 1994;309:1730-3.

3 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8.

4 Core values for the medical profession in the 21st century. Report of a conference held on 3-4 November 1994. London: BMA, 1995.

World Health Organisation: change and progress

Ilona Kickbusch

As it nears its 50th anniversary, the World Health Organisation today is being subjected to closer scrutiny than at any other stage of its history. In a world that has changed immeasurably since the late 1940s, WHO's role as the leading international health agency is more important than ever. The organisation now must show itself fit and ready to confront new, bigger, and more complex challenges of global health.

Inevitably, at a time when the United Nations system as a whole is under close and often hostile examination, WHO—as a UN specialised agency with a particularly high profile—is taking its share of criticism. The challenge is enormous.

"The World Health Organization's half century amelioration of suffering stands out as a singular achievement in international cooperation. Nevertheless, innumerable health problems, inadequately addressed by the international community, remain and stand as testimony to WHO's limitations and unrealistic goals. The Organisation's ability to adjust to these challenges in the next few years will determine the role it will play in solving global health problems in the future. The future direction and role of WHO are attracting more interest, and debate continues over how best to approach reform." This is an excerpt from

an article by John W Peabody that appeared recently in *Social Science and Medicine*¹ and which attempts to address the many difficulties facing WHO and its strengths and weaknesses. Unfortunately, the same cannot be said for the *BMJ*'s recent series of articles on the organisation by Fiona Godlee, which makes little attempt to grasp the real issues at stake. The many mistakes in the series could be excused, but from beginning to end there has been little trace of fair-mindedness. The result is unworthy of the *BMJ*.

We were left with the uneasy feeling of a hidden agenda, particularly after reading the editorial on the organisation in the issue of 4 March with the subheading "Reform must begin now but will depend on a new leader."² This could easily be read as part of an electioneering campaign on behalf of an anonymous candidate for the post of director-general of WHO when it next becomes vacant. In any case, it is simplistic to argue, as the editorial does, that finding and electing some visionary figure "in the mould of Gandhi or Nelson Mandela" for the post is the solution to the complexity of global problems that currently exist. Faced with that complexity, WHO's member states, as always, will make their choice.

Our response cannot attempt to rebut all or even

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BMJ 1995;310:1518-20