A small earthquake?

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Clin Med JRCPL
2002;2:212-6

ABSTRACT – In recent years, concerns about health and healthcare have been expressed by the public, the profession, patients and politicians. These are neither new nor confined to the UK. Doctors were not always held in high public esteem; that had been earned over the last 150 years through scientific discoveries such as anaesthesia which revolutionised patient care. The turbulence of the last few years has a number of causes, including increasing patient expectations. Perhaps inevitably it has again called into question the relationship between government, the public and the profession. The resulting debate has been more widespread and better informed than previous episodes of dissent, perhaps indicating a greater willingness on the part of all three parties to assess their relationship anew. Any such assessment would no doubt have to accept the current workforce difficulties experienced by many doctors and other healthcare professionals practising in unsatisfactory circumstances.

KEY WORDS: CPD, General Medical Council (GMC), medical education, medical standards, unhappy doctors, revalidation

Introduction

Looking back, it has been a little turbulent. For all of us – public, patients, politicians and profession – with an interest in the quality of our health services, the last few years have not been easy. The problems affecting cardiac surgery at Bristol Royal Infirmary and pathology at Alder Hey¹ were compounded by apparently innumerable examples of unacceptable clinical practice. Harold Shipman was found guilty of murdering a number of his patients and may have killed many more. Complaints referred to the General Medical Council (GMC) increased from around 1,500 in 1997 to more than 4,500 in 2000. The organisation strove to cope with the additional workload but the delays that developed caused concern to both public and profession.

And yet, at the same time there were other, sometimes conflicting, developments. The public, media

and politicians became increasingly aware of deficiencies in the care provided by the NHS. Patients with cancer and cardiovascular diseases were shown to fare less well in the UK than in a number of other countries; seriously ill patients were often kept waiting on hospital trolleys because of a shortage of hospital beds. These deficiencies and continuing public support for the NHS led to the production of the NHS Plan (for England)² that indicated the Government's strategy for improving the health services. While the Plan was widely welcomed, concerns were expressed at the shortages of almost all grades of staff and the additional resources required to produce a modern health service for the UK. NHS Plans for the other three UK countries have been produced, and the four National Health Services are developing distinct directions. There is now a growing appreciation of the magnitude of the under-investment in the NHS, the time that will be required to remedy the deficiencies, and the difficult circumstances in which many NHS professionals now work. The debate about how best to provide high quality health services continues with the recent publication of the draft Wanless Report³. The tenor is, however, different; both better informed and less tendentious.

Two other factors may be relevant. Patients still trust their doctors; at least 91% do – a higher proportion than for other professions⁴. The NHS remains remarkably cost effective. There are few examples from any other country of a health service that provides a better service for patients within the resources available to the NHS. Nevertheless, additional funding, while essential, may not be sufficient on its own to produce the desired improvements. Scotland currently spends around the European average on health and about 22% more than England; problems of waiting times and relatively poor patient outcomes are, however, similar.

The questions remain: is the recent turbulence the result of a small earthquake in some distant land registering low on the Richter scale, or does it signify a greater movement of tectonic plates? Are we witnessing a real realignment of the relationship between the government, the public and the profession? Are we players in what others have described as 'the rise and fall of the medical profession'? What, if anything, is the role of the GMC?

Background

Medicine has a long and distinguished past. From ancient Greece onwards the benefits for the individual patient and to mankind have been well documented⁵. Yet it remains true that prior to the middle of the nineteenth century, the medical profession was not generally held in high public regard. Quacks and patent medicines were commonplace; treatments, such as bleeding and cupping, often caused more harm than good.

It was the rapid development of the scientific foundations of medicine that attracted public attention. Increasing understanding of sepsis and infectious diseases, including tuberculosis, and the spectacular developments in anaesthesia, obstetrics and surgery, persuaded the public that the advances in medicine had much to offer the individual patient. The GMC was established in 1858 as the General Council for Medical Education and Registration of the United Kingdom⁶ in order to assure the public that doctors on the medical register throughout the UK were appropriately educated and fit to practise at a time of rapid change. Such was the popular enthusiasm for the new scientific discoveries that medical education and the provision of healthcare changed radically around the beginning of the twentieth century in the UK, Europe and North America. The Flexner report⁷ in the USA confirmed that the Johns Hopkins Hospital Medical School in Baltimore, which had pioneered close links between clinical and basic science, provided the best model for future developments in research, education and clinical practice. When Flexner went further and proposed that academic staff should become full-time faculty members and give up their private practice, William Osler, who had led the developments at the Johns Hopkins and had subsequently accepted the Regius Chair at Oxford, objected. He was concerned, perhaps presciently, that research might become the dominant activity of the medical school. Osler believed that scientific advances were important,

but only a very narrow view regards the Director of a University clinic as chiefly an agent for research. He stands for other things of equal importance. In life, in work, in word and in deed, he is an exemplar to the young men about him, students and assistants ... A great gap would be left in the education of a clinical teacher who had not known that inner life of the public which we meet in our ministry of health⁸.

Whatever the rights and wrongs of this argument, still perhaps not fully resolved, such was the public demand for better quality and more available healthcare that health services developed in different ways across the world. Our National Health Service was established in 1948, although the debate about its scope and funding had begun many years earlier. Its advent sustained the public support for medicine and doctors – support that was further strengthened by the considerable numbers of popular books, films and eventually television programmes all centred around medicine. In those days, doctors were inevitably portrayed as handsome heroes.

From general practice to acute hospital specialties, almost all aspects of medicine were glamorised. In time, many doctors participated in this approach, partly no doubt to help satisfy the

Key Points

Complaints about doctors have risen considerably in recent years

The problem of 'unhappy doctors' is not confined to the UK

Patients continue to trust their doctor

The medical profession now accepts the need for greater accountability and has accepted the need for appraisal and revalidation

The shortage of doctors and other healthcare professionals, together with the need for more funding, is now widely accepted

The relationship between the public, the profession and politicians may be undergoing a small but significant change with doctors and patients working more closely together

public demand for matters medical, and partly because the resulting publicity was useful for raising funds and generating grants. Expectations that could not be fulfilled were raised (Richard Nixon's war on cancer); this at a time of spectacular advances in many fields of medicine (transplantation and cardiac surgery). In retrospect, it seems inevitable that the bubble would burst.

An educated public were no longer grateful for medical care which they regarded as their right – and were no longer concerned that the costs would have to be met by the family. As consumers, they expected an efficient health service that was sufficiently flexible to meet their needs. Increasing access to information often led to a situation in which patients and their relatives were at least as well informed on individual topics as the doctors themselves. Perhaps more importantly, patients rapidly came to understand that many of the recent advances in treatment were not risk free. For many reasons, the concept that even conscientious doctors may make mistakes, sometimes with serious consequences for the patient, has until recently been difficult to debate in the UK. That has introduced a tension between those who believe that the health service will improve only when doctors and others are able to discuss openly some of the problems that have arisen and those who advocate a 'name and shame' policy. Both approaches are needed. Audit and debate have to be open if we are to learn from the experience of our colleagues and patients. Doctors, however, must adhere to the standards outlined in *Good medical practice*⁹, particularly when there are problems with the health service in which they work.

The concerns expressed about doctors by the public, politicians and the media are mirrored by the unhappiness felt by a number of doctors¹⁰. The problem of the 'unhappy doctor' is not confined to the UK but has been noted in many countries, from the USA and Canada to Australia and New Zealand. Increasing workload is responsible for some of the problems but the decrease in autonomy is probably more important. Across

the world, doctors are increasingly being held accountable for their actions. Guidelines, recommendations and audit may help improve clinical standards and outcomes for patients but are also perceived by some doctors as restricting their ability to act in the best interests of the individual patient. The strength of feeling on both sides of the debate is as ever matched by the weakness of the evidence base.

Within the UK, increasing workloads with an insufficient workforce add to these concerns. The shortage of consultants and principals in general practice is compounded by the decrease in the hours that doctors in the training grades are now legally allowed to work. The result is often an unacceptable increase in the intensity of work during periods of duty. Retention of good doctors is becoming as crucial a task as recruitment.

The ways in which the government and the NHS have responded to these pressures may indicate a more fundamental change in the relationship between government, the public and the profession. If that proves correct, the role of the GMC will also alter. What are the issues of immediate importance to the GMC and how do they relate to the pressures experienced by the NHS?

Future direction of the GMC

In some ways, we have come full circle to the 1858 Medical Act which portrayed the core role of the precursor of the GMC as assuring the public that registered doctors are competent. Revalidation is a logical consequence of that view. Add to that the tasks of defining what is implied by fitness to be on the register (standard-setting), protecting the public from unfit doctors (fitness to practise), and providing quality assurance of entry to the register (education and registration), and we have a broad picture of the current role of the GMC.

Standards

The GMC is responsible for defining the standards expected of doctors. Our current guidance, *Good medical practice*⁹, originally published in 1995, is a positive affirmation of a doctor's duties and is updated regularly to take account of changing circumstances. It also provides the basis on which a doctor's fitness to practise may be called into question. Agreeing and promulgating standards, educating students to meet these standards and dealing fairly and effectively with those doctors whose practice falls short of the agreed standards, lies at the heart of our guidance for doctors and the protection we provide for patients.

Education

The success of *Tomorrow's doctors*¹¹, produced in 1993, had more to do with the effective way in which it was implemented than with its contents; most of the recommendations had been published a decade earlier to little effect. The new curricula envisaged in *Tomorrow's doctors* are only now fully established

with graduates entering the pre-registration house officer (PRHO) year and training grades. And yet such is the current speed of change that a new version of *Tomorrow's doctors* has been widely circulated for consultation (on the GMC website: www.gmc-uk.org), the number of medical undergraduates in England increased by around 40% over the last few years, four new medical schools have been established, graduate entry boosted and multidisciplinary education strongly promoted. Fortunately, despite the recent problems experienced by the NHS, the number of well-qualified applicants to study medicine has remained more or less unchanged over the last 15 years at around 8,500–9,000. No doubt the number of applicants could be increased at any time by reducing the entry requirements – and there are good grounds for considering how best to include some form of aptitude testing, as has already occurred in other countries, notably Australia.

Those applying for graduate entry already have evidence of their abilities. By seeking to encourage applicants from beyond the currently accepted route of a first degree in the biomedical sciences, there is an opportunity for medical graduates from different backgrounds and thus with potentially different approaches to the needs of patients and the medical profession generally. At present the demand from graduates to enter medicine remains high, with many accepted for courses which have a significant component of interprofessional education¹².

For the foreseeable future, however, it is likely that most medical undergraduates will come from school. Special study modules and the opportunity of an intercalated degree help ensure that medical undergraduate education is sufficiently broadly based both to maintain the motivation of the high calibre students and to ensure that doctors are fully equipped to face a future full of change. The concept that universities must take an interest in ensuring that medical graduates not only have high academic standards but are fit to practise has now been accepted by both the Council of Heads of Medical Schools and by the Universities UK¹³. As medical graduates, unlike graduates in the other health-related professions, are automatically granted provisional registration with the GMC and so have the right to practise, albeit under supervision, there is an onus on the universities to ensure that their graduates do not put patients at risk.

The statutory remit of the GMC's Education Committee is to promote high standards in, and coordinate all stages of, medical education. While the impact on undergraduate education may have been considerable, the same cannot be claimed for postgraduate training. Our recommendations for the PRHO year (*The new doctor*¹⁴) have met with some success but little has yet been achieved to improve the lot of SHOs, despite widespread acceptance of our guidance, *The early years*¹⁵; perhaps the working party led by the Chief Medical Officer for England will have greater success. The current arrangements for the SpRs, organised by the Colleges, are acceptable, but the GMC has offered little guidance on what doctors should expect from participation in meaningful continuing professional development (CPD) activities.

Given the importance of the links between these educational

requirements, appraisal and revalidation, the GMC must now clarify what is expected of individual doctors. The Colleges and others will then be able to provide the necessary practical guidance and courses to assist members and fellows to fulfil the requirements for revalidation.

The proposals, now out for consultation, on the Medical Education Standards Board (MESB) are likely to prove controversial – perhaps particularly with the Academy of Medical Royal Colleges and with the individual Colleges. Whatever the outcome, it is essential that the new Board and the Education Committee of the GMC cooperate fully to ensure that the standard of education and training provided enables doctors to meet the needs of patients in the years ahead.

Revalidation

All doctors who want to retain a licence to practise must be able to demonstrate – on a regular basis – that they are up to date and fit to practise medicine. For the majority of doctors working in the NHS, satisfactory outcomes from their annual appraisals will go a long way towards satisfying the requirements for revalidation. The information for both appraisal and revalidation is based upon the seven principal headings from *Good medical practice*, as shown below.

Good clinical care: doctors must practise good standards of clinical care, practise within the limits of their competence, and make sure that patients are not put at unnecessary risk.

Maintaining good medical practice: doctors must keep up to date with developments in their field and maintain their skills.

Relationships with patients: doctors must develop and maintain successful relationships with their patients.

Working with colleagues: doctors must work effectively with colleagues.

Teaching and training: if doctors have teaching responsibilities, they must develop the skills, attitudes and practices of a competent teacher.

Probity: doctors must be honest.

Health: doctors must not allow their own health or condition to put patients at risk.

Additional evidence from an audit of current practice, from colleagues and patients and from participation in CPD, will be required for the revalidation folder – as well as information on complaints. In reality, however, it seems likely that the data collated for appraisal will constitute the bulk of evidence required by the majority of doctors for revalidation.

Registration

Maintaining the Medical Register of those who are fit to practise is the principal purpose of the GMC and lies at heart of our

commitment to ‘protect patients and guide doctors’. At present we have different forms of registration – full, limited and provisional – and different methods of obtaining them. UK graduates obtain provisional registration automatically on graduation from their university, and full registration on satisfactory completion of their PRHO posts. Citizens of the EU who have qualified in a member country obtain registration on request. Overseas doctors are able to apply for limited registration only after passing Professional and Linguistics Assessment Board (PLAB) or seeking another route of registration (sponsorship or specialist routes). I hope that we shall be able to rationalise this complex system of registration in the near future – both to ensure transparent equality of opportunity and to remove any unnecessary barriers to doctors wanting to work in the UK. For the foreseeable future the NHS will be dependent on non-UK doctors to help staff the NHS. At present, the number of UK graduates is exceeded by doctors joining the NHS from other countries.

Reforms

At present, the GMC has proposed a number of reforms to government. These will require legislation, and we await the details of ministers’ response. The reforms include proposed changes to the governance of the GMC itself (reducing the size of the Council from 104 to 35 members and increasing the proportion of lay members from 25 to 40%), the introduction of revalidation, and the reform of our Fitness to Practise procedures. We wish to simplify these and separate our investigation function from adjudication. These changes, together with a number of administrative alterations within the GMC itself will, I believe, make our procedures more efficient and effective without losing the essential element of fairness both to the patient and to the doctor. All of these matters have been approved by Council.

The government has, however, made a number of additional suggestions. Chief among these, and as indicated both in the NHS Plan for England and in the response to the Bristol Inquiry, is the creation of a Council for the Regulation of Healthcare Professionals (CRHP). While many of the proposals for the new Council are welcome (seeking to promote greater integration across the professions, for example), some require greater clarity. It is an important principle that individual statutory regulators, such as the GMC, should be directly accountable to Parliament, and not to some other body, such as the proposed new Council. The current position is far from clear; while we welcome steps to clarify the proposals, the result must, I believe, be compatible with this fundamental principle. Secondly, it is important that any requirement for the GMC to change what it considers good practice should again be agreed by both Houses of Parliament. Only in that way can the independence of the GMC as a regulator be guaranteed. That guarantee is essential if the confidence of the profession is to be retained – and, more importantly, the rights of patients protected. Standards of care for patients are generally low in those countries where the state is the monopoly employer and also solely responsible for the

education and training of doctors and other healthcare professionals. The need for professional standards remains as great as ever if patients are to be protected and high quality care maintained. Hence the importance of ensuring the continuation of professionally led regulation. As a profession with a distinguished past and an exciting future, the patient must remain at the heart of all that we do.

Conclusions

Perhaps the turbulence of the last few years has inevitably called into question the relationship between government, the public and the profession. The resulting debate has been more widespread and better informed than previous episodes of dissent, possibly indicating a greater willingness of all three parties to assess their relationship anew. Any such assessment would no doubt have to accept the current workforce difficulties experienced by many doctors and other healthcare professionals working in unsatisfactory circumstances. Looking forward, however, there may be merit in re-examining the rights and responsibilities of all the partners, so that each can more fully understand its contribution to future high quality healthcare. There are indications that the profession and the public are working more effectively together than in the past. If that proves correct, the role of the GMC may become more clearly understood and less contentious. The onus will, however, remain on government to clarify the rules of engagement.

The tremors of the last few years were, I believe, real and resulted from a movement of the tectonic plates quite close to home. So far, damage appears limited. Perhaps, like a kaleidoscope, the picture has been improved by the small shake-up?

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