

# The shape of things to come?

Transcript of GLADD's inaugural Peter King memorial lecture, given by Professor Graeme RD Catto, 17 March 2001 at Guy's Hospital, London.

## Introductions

Professor David Harvey, GLADD's co-chair, introduced the annual Peter King memorial lecture. David said that Peter had decided to found GLADD after Peter and Huw had had lunch at David's home. Our predecessor organisation, the Gay Medical Association, had folded and Peter was clear that there was still a need for a similar organisation in the mid-1990s when GLADD was founded. It was a great sadness to us that Peter died of bowel cancer on 23 May 1999 and GLADD has decided to set-up an annual lecture in memoriam of Peter.

Huw Owen-Reece, Peter King's partner, introduced our guest speaker, Professor Graeme Catto. Huw said that he and Peter had first met exactly fifteen years ago at an event organised by the Gay Medical Association. Professor Catto is Dean of Guy's, King's and St. Thomas' medical school, Vice-Principal of King's College London and Chair of the general Medical Council's Education Committee. Huw welcomed Professor Catto to the lecture.

## Lecture

### Introduction

Thank you very much indeed for the invitation and the honour of delivering the first Peter King Memorial Lecture. Thank you also for the introduction. I have begun to collect introductions as I have gone round the country and I was introduced, about a month ago by once chairperson, as the consultant who had looked after her husband when he was alive. Tonight's introduction is certainly an improvement on that! Before I start, can I say how pleased I am that so many of you have come? It is, I think, a bit of an ordeal to come to a medical environment for a lecture like this, and perhaps even more so to encounter someone like me, so I am grateful that so many of you have had the fortitude to be here; I am not unaware of the courage that that takes in a situation like this.

I entitled the talk 'The shape of things to come?' because I think there are lots of things changing in the medical environment at the present time which will affect you and affect the rest of us. What I would like to do is to stimulate some sort of debate this evening about those different issues.

### Peter King

I want to start off where Huw began, by saying a word or two about Peter King. I did know Peter very slightly; he was involved in the organisation of a drug trial on transplantation when I was much younger and so I knew him through that. I found him to be, as many of you will have known him, to be a modest character but quite charismatic at the same time. He was, as you know, a physician with an interest in the pharmaceutical industry, and he was an enormously sociable individual and someone who liked to travel very widely. He was, as you have heard already, the founding father behind this organisation. He was open, honest and, perhaps sometimes too honest for his own good. There will be many of you in this room who have your own memories of Peter King and it is a great privilege for me to be invited to deliver the first lecture in his memory.

### Discrimination in the medical profession

As part of the preparation for this evening, I looked through some of the literature which GLADD has produced. I found it to be strangely moving, with a wistful quality to it, as though people were hoping for better and have been consistently disappointed with what has happened to them and about them. There's the fear that comes through – the fear of overt homophobia of course, but I think it is perhaps more subtle than that now; I think there is what you have called 'internalised homophobia', but also the subtle discrimination which I have no doubt goes on all the time in the NHS. Discrimination of all sorts is alive and well, unfortunately, in the NHS. Harassment and bullying remain problems and I think not just for members of this organisation

but for lots of other young people who are trying to make a career in the NHS. Throughout your literature, and particularly in the recent workshops which GLADD has held, there are frequent references to the GMC and what you think either should be doing or could be doing. Perhaps I might talk about some of these later on this evening.

The current position of the GMC is enshrined in paragraph 28 of 'Good Medical Practice' which makes it very clear that you must always treat your colleagues fairly. The second sentence in the same paragraph says that you must not allow your views of colleagues' lifestyle, culture, beliefs, race, colour, gender, sexuality or age to prejudice your professional relationship with them. In my view, that is essential, but it may not be sufficient on its own. There may be other ways in which we can help and take this issue forward – not just the issue of homophobia, but also covert discrimination and harassment, if not genuine bullying.

One of the issues I have not yet talked about is the access to medical training and what we should do with disability, and what disability actually means in this context. I picked up the 'BMA News Review' yesterday and was reminded that this is still an issue, as they were discussing a young woman who is paraplegic and is having difficulties gaining admission to Oxford University to study medicine. The GMC may have played a part in this and the matter is currently the subject of an industrial tribunal. However there may also be issues surrounding hepatitis B, HIV, disability and access to medical training – issues which we may like to pick up on later in the evening.

### **Reform of the GMC**

If we look at the future arrangements for the GMC, there is an opportunity for GLADD to enter the debate quite forcefully. 'Good Medical Practice' is being revised and the current draft is out for consultation. If there are issues there which GLADD thinks should be strengthened or changed, now is your opportunity to raise them. The original document was produced in 1995, revised in 1998 and the current proposed changes are relatively small. They bring together two booklets – 'Good Medical practice' itself and 'Maintaining Good Medical Practice'. The other booklet which is being revised at the same time is the guidance which the GMC gives to the undergraduate medical schools – 'Tomorrow's Doctors'; that is far less advanced and we are hoping to present a revised text to the GMC Council in May. The educational changes are likely to be small, because 'Tomorrow's Doctors' has only just been implemented, having been first produced in 1993. The first cohorts of students coming through the new curriculum are just beginning to graduate now. If you think there are other changes, perhaps to do with disability, perhaps discrimination issues, which need to be strengthened, let me know. Although the content will only have subtle changes, the style will be dramatically different. It will link much more closely with the current GMC booklets, so it will be in a style that is not unlike 'Good Medical Practice', 'The New Doctor' and other GMC publications.

There are, perhaps, three or four big changes which are happening to the GMC at the current time. First of all, the governance of the GMC is being looked at; this is one of these internal debates in which people look at the structure of the organisation and decide whether the structure ought to change or not. Of course people have made the usual mistake by looking at the structure without first looking at what the function of the GMC is. There is a danger of putting the cart before the horse: the structure can only be relevant if you look at what the function is and whether the structure helps or hinders that. Nevertheless, the GMC is going to change quite markedly. It is an organisation with 104 members at the present time; the majority are elected doctors, but a substantial minority, about 25 or so, are appointed from the royal colleges and from universities with medical schools, plus a similar number of appointed lay members. In the future, whichever specific model is picked, we are going to end up with a Council which is much smaller, probably between 60-80, still with a majority of elected doctors, but a greatly increased proportion of lay people, perhaps up to fifty percent, and a very much smaller proportion of appointed members, in the region of five or six, which would be perhaps ten percent of the membership. These things matter enormously because we have little control over the lay people who are appointed to us: they are a very high standard, but their appointment procedures in the past have been hidden in lists and they have ended up as Secretary of State appointments without any of us having any clear idea, indeed they themselves not having any clear idea, of why they were picked for that purpose. So I think we are likely to see a much more open process for selecting people – a system where people can

apply on the basis of their CVs and certain qualities that the GMC is looking for in terms of lay people.

The whole arrangements for fitness to practise are also changing, which I will address later. As part of this maelstrom, the Education Committee, which is at present a statutory committee as part of the GMC, so it cannot be got rid of except by primary legislation, is also being changed. And somewhere, over-arching all of these concerns, there is going to be a UK-wide body that brings together all of the regulatory bodies, bringing together nurses, dentists and doctors into a common regulatory framework. That may or may not be a good thing, but it is likely that doctors will remain a distinct group within that bigger umbrella organisation.

I have told you a little bit already about the governance proposals. These are now out for consultation and you have probably already received the full document or a summary document about the proposals. It is likely to end up with some sort of 'penny farthing' model where a Council of between 60 and 80 is led by a much smaller executive group, perhaps between 10 and 20 people. That executive group would not just have devolved powers but would probably also have statutory powers. It is the balance between the smaller body and the larger body which is going to be enormously important. As well as having a President of the General Medical Council, who would still be a medical person, and would chair the smaller body, the proposal is that there would be a chairperson of the Council itself and that that person would be lay. So the lay voice in the GMC is going to increase quite markedly over the next few years. You should have views in this because it is going to change the ways in which medicine is organised and is going to change the way in which medicine is perceived.

We keep on thinking of the General Medical Council in terms of what it does to doctors who have erred – the 'difficult doctor' who gets erased or suspended, but the organisation also sets the tone for the way in which medicine is practised and sets the standards. This is going to change in accordance with Society's wishes. Of course Society itself is beginning to express very strong views on way in which medicine ought to be practised in the UK.

### **Fitness to practise**

I shall look very briefly at the fitness to practise issues. The number of complaints received each year is increasingly quite remarkably. Only three or four years ago, the GMC was receiving only 1200-1500 complaints per year; last year that rose to just under 4000 and this year it looks this we shall exceed this. So there has been a three- to four-fold increase in the number of complaints. Some of these are quite awful cases – you have seen these in the Press already and it is hard to believe that colleagues could behave in those ways, but of course many of the complaints which the GMC receives never go any further than the screening process. That is largely because the public are totally confused about how they should best make complaints. It is not just the public – I guess the profession itself does not really know where it should go when there is a colleague about whom they have concerns or a situation which they have doubts. There is everything to be said for trying to link whatever the GMC ends up doing very much more clearly with whatever the NHS is doing. I think this is absolutely right; the health service should take a very much greater interest in the way in which its own employees are working and collaborating together.

It has been said by some of the Ministers in power at the current time that they do not wish the debate to go very much further at the moment, but they do anticipate having a greater degree of clarity in how best to organise the complaints procedures once the next election is over. I think there is a huge demand from constituency MPs as well as lay people to try to get much greater clarity into how that should be handled, so the GMC ends up complaints that would actually affect their registration and hence their ability to work at all, and not just their employment in one trust or one general practice as opposed to another. In order to be taken seriously at the present time by the GMC, the complaint has got to be of such severity that it would actually affect a doctor's ability to work – it would affect his or her registration.

But as well as the Professional Conduct Committee which can erase your name from the register or suspend you, we now have the Professional Performance Committee so that if you consistently perform under par then you can be assessed and you can either be given additional training or you can be erased for that reason. SO there are various forms of fitness to practise

committees now being set up to assess your fitness in your specialty and whether or not you should be allowed to see patients. For each person who goes through that performance committee, the cost is about £15,000; that is money which you pay because that money comes off your registration fee. As you know, the registration fee has increased over the last two or three years and it is set to rise very much further yet, simply because of all those complaints. Of course it is not possible to sustain that degree of expenditure, and we cannot possibly afford to spend £15,000 assessing every single doctor whose performance comes into question. There is no doubt that the National Clinical Assessment Centre, when that comes into being, under the direction of Dr Alistair Scotland, is going to spend a great deal less than that, in assessing doctors' performance. Finally we have got the health procedures, which have worked reasonably well since they were introduced in the 1980s.

All of this is, I think, going to be changed quite dramatically by the Human Rights Act. It is not possible any organisation, let alone the GMC, to act as judge and jury in this situation. You cannot have an organisation that both sets the rules and decides whether you have obeyed them or not, and then also sets the penalty. So there is going to have to be a separation of the prosecution from the sentencing powers of the GMC. This will affect you, it will affect every one of us, so it really is important that you respond to the consultation. One of the problems of the GMC is that it is fiendishly democratic, so that if you do actually put in a response, it will be paid attention to, it will count, and the situation will change because of that. So I would very much encourage you to read the consultation documents.

### **Medical education**

Looking at the Education Committee, it is a statutory committee which was set-up under the 1983 Act, it is there to promote high standards in medical education. It is also there to do something that, I suppose, we have not done very much of in the recent past, that is to co-ordinate all stages of medical education. We have not done very much by way of the co-ordinating activities so far. We have probably been 'all right' at an undergraduate level. If you look at how British medical undergraduate education stands in the World context, we are probably 'all right'. If you look at what is happening in the USA, Canada, far East, Europe, Britain's performance is, I think, respectable, and the document 'Tomorrow's Doctors' has had an impact, not just in Britain, but in Japan, America and Europe as well.

If you look at what we have done at the postgraduate level, we have probably been completely ineffectual. That is probably because there are so many groups beginning to become involved in that particular arena. We have the postgraduate deans who are beginning to emerge and strengthen their muscles. We also have the royal colleges – and if you look at the colleges the pass rates and the assessment procedures which they have for the different exams, they really do not bear very much scrutiny at the present time. They are not, probably, able to be audited in an objective way and there is a lot of work to be done, I think, to bring the colleges into a much more coherent pattern. And then, of course, we have the regulatory authorities themselves – the statutory authorities: the specialist training authority which allows you to become a specialist in the hospital series, and its counterpart in general practice the joint committee. These are under the sentence of death and the Government is suggesting they should be amalgamated and brought together under a medical education standards board. Again, there is everything to play for in postgraduate education if we think that the current situation is not well organised.

If we look at 'Tomorrow' Doctors', we have probably got that right and it has probably been quite a success. If you look at what we have done at the Pre-Registration House Officer level, in 'The New Doctor', we probably have not done that terribly well. As I go round the country, it is very patchy. Some trusts have got good programmes in place, some are unbelievably disastrous. I went to a trust a couple of months ago to speak to some of the PRHOs there and they now have all of these educational meetings, including bleep-free time so they are not interrupted, but the first educational meeting they went to at this trust was entitled 'Preparing for retirement'. This says something about the NHS or the insurance company which was sponsoring the talk.

If you look at what we have suggested for Senior House Officer training 'In the early years', well nothing has really happened at all. It is a nice booklet, but absolutely nothing has happened.

Although we talk about a continuum of medical education, from entry into medical school through the undergraduate years, PRHO year, SHO, specialist registrar and moving on to continuing professional development, there really is no coherence across these divisions. So the concept that medical education is a continuum and that what you start at an undergraduate level will continue until the day you retire is hot air at the present time, but then you knew that and I knew that as well, but I think that is unlikely to continue.

If you look at the internal environment that is affecting the General Medical Council at the present time, we have talked about the 'navel gazing' and the fact that the structure is going to change; we have talked a little bit about the change to 'Good Medical Practice' and 'Tomorrow's Doctors'. But of course we organise undergraduate medical education by going on visits to medical schools, so it is very clear who is in charge of that – the local Dean is in charge so that if things go wrong, it is he or she who carries the can. So the series of informal visits that we have had since we introduced 'Tomorrow's Doctors' have been quite successful. We have now had the second round of those visits and they finish in April of this year. Thereafter we need to decide what we are going to do. My view is that we then need to go ahead with formal inspections, looking at the way in which 'Tomorrow's Doctors' has been implemented. We shall start that from the year 2003.

At present we graduate somewhere between 5,000 and 6,000 medical students into PRHOS each year, and this figure will rise by around 1,000 over the next four years, and it will rise by a further 1,000 the year after that, with the round of bids for new medical schools which are in place at the current time. So there will be around 7,000 newly qualified doctors graduating from UK medical schools each year within the next four or five years.

That will still be less than fifty per cent of the doctors we need. We import many more doctors than that, perhaps taking in 10,000 doctors from abroad each year. The exam which we require them to sit, the PLAB exam, is very different to the exam which we expect UK medical students to sit. We have no control over the graduates coming into the UK from Europe because of the freedom of labour laws. There may be a lot to be said for trying to bring all of the differing exam systems much closer together. If the PLAB test is a reasonable test, and it does determine what we expect overseas doctors to know when they come to this country, why is it wrong for our own graduates to aspire to that standard? As I am sure you know, there was an informal assessment of the PLAB test undertaken by a couple of our own universities and of the fifty UK PRHOS and medical student that sat the test, only two passed it. That either says something about undergraduate medical education in the UK, which it may well do, or something about the PLAB test as it was. Partly because of that, the PLAB test is being revised, really quite substantially, but there may well be a reason to move towards a co-ordinated form of undergraduate medical education across the UK; not necessarily a national curriculum, but perhaps a final exam in which there are common elements so you can reassure the public and politicians that there is some sort of sensible standard across the UK. That, of course, would make overseas graduates, who come to this country, a little more comfortable, that they were being assessed in a reasonably obvious way and that this was free from discrimination.

### **Revalidation**

Looking at revalidation and the problems which we are all going to face with that, we have agreed that for those doctors in training then revalidation should fit very closely with the RITA forms and appraisal procedures that they already go through. But they cannot be precisely the same. It will be perfectly possible for some people to fail revalidation and yet pass their educational milestones and vice versa. And it is precisely the same situation at an undergraduate level, where we need to deal with those people who are academically bright but who, for whatever reason are not fit to practise medicine and are not fit to see patients. You cannot link directly educational attainment with the ability to practise medicine.

Revalidation, then, needs to be looked at very much more carefully than perhaps the GMC has done at the present time: the concept is probably widely accepted, but the bureaucracy behind trying to get all of the information that will be required to produce a portfolio or folder, and allow yourselves to be assessed once every five years and revalidated, really has got to be slimmed down. For the vast majority of doctors, whose appraisal has been satisfactory year on year, then the expectation ought to be that revalidation will also be sensible.

But there probably is need for external scrutiny, there probably is need for an outside body to make sure that the revalidation process is robust. The reason is that, if you have a trust, which is under enormous pressure from ministers or government, to fulfil waiting list targets and to make sure that patients aren't kept waiting too long, it may be in that trust's interests to keep going with a doctor whose performance is under par and known to be poor to patients, simply because of his or her influence on the speciality and its waiting lists. So we could see a situation where there is connivance between the doctor and the trust to keep that person in post for political or medico-political reasons. We have seen some examples of that, I think, in recent years, where some of the doctors that came before the GMC were known to be performing very badly over a number of years and yet the local management of that trust, for whatever reason, had not dealt with it. It is not often that these very high profile cases come to the GMC without any background. There is very nearly always a background with colleagues and managers already knowing a great deal about the situation before it comes to the GMC. I suspect a good example of that, when the report is published later this year, will be the Bristol Inquiry. The Department of Health, local officials, management and Bristol, were well aware that that particular specialty was under performing long before the high profile case came to the GMC and indeed many of us would wonder why it came first to the GMC. It seems to be that there was good reason there, to think that there might have been a Department of Health inquiry first, pretty much as there was at Alder Hey, with any conduct problems being picked up by the GMC thereafter. It is interesting to know how these things come about and who makes the decisions.

### **Educating more doctors**

There is, of course, an external environment to the GMC as well. There is a political environment; there's an NHS plan which talks about short medical courses. It says that for postgraduates we ought to be thinking of three year courses and for undergraduates, that is people who have not got a previous degree, we ought to be thinking about four years. The difficulty with that is that the Government is signed up to the European Directive and, as part of European law, you have got to have six years of medical education, or a minimum of 5,500 hours of teaching. Britain subscribes to that only by including the house officer year in the years of undergraduate education. SO although the universities have no direct control over it, in the sense that PRHOs are employees of trusts, nevertheless it is regarded as an educational year and it will have to stay that way. So if you are going to shorten courses, the only way you can do that is by taking into account previous experience, i.e. if you have people who come into education with prior experience, which would have to be under the auspices of a university, you could reduce the length of time for which they are trained. That, I think, may be one way forward and that has been the most popular way of universities trying to address the desire to decrease the length of courses. Of course this creates a tension for the Government, who are desperate to get the medically qualified workforce increased versus the need to have an educated workforce and educated doctors. Young school leavers coming into medicine today will still be in clinical practice in the year 2040 or 2050; it really is quite important that they have an education and simply are not trained to do endoscopies, for example, or whatever happens to be the flavour of the month at the present time. They need to understand that changes that are likely to occur over the next forty years of their working lives. So we are going to have increased medical student numbers, we are going to have different forms of medical schools, no doubt and we are going to have new medical schools training doctors in slightly different ways. So there is a need, I think, to be sure of the outcome of that education and to ensure that patients are not going to be put at risk.

At last, the Government and the Chief Medical Officer, has grasped the problem of the SHO years. As you know, there is a committee under way at the present time which is reviewing that. My understanding is that the committee is going to report later this year and I think it probably will produce a radical review of the SHO grade, which is an appalling situation at the present time.

Medical Education Standards Boards, a Government creation, were supposed to bring together the Specialist Training Authority and the JCPTGP, but of course it also, if things go wrong, could take over undergraduate education. I do not think that the GMC's position in controlling

that is without risk. It may well be that that too will be removed from that GMC if we do not perform a bit more effectively.

The QAA, the Quality Assurance Agency, which looks after many other departments in universities, is also getting interested in health, and will pick up the bits and pieces for nursing and some of the other allied health professionals. It already picks up the undergraduate medical course at a technical level in the universities and there will be a need for the GMC and the QAA to work together, particularly as they produce bench marks for undergraduate education.

There is a huge push at the present time for multidisciplinary learning. The evidence base for that is weak, but the need for doctors to work constructively with other groups in the healthcare professions has never been greater.

### **The medical profession and its relationship with the public**

Another way of looking at what is happening to medicine is to look at a map of London which shows the areas of greatest deprivation and compare it with a map of where doctors live. The two hardly coincide at all, with most doctors in London living in Hampstead and Dulwich, not exactly known to be areas of much deprivation at the present time. Yet many of us, looking back maybe twenty or thirty years, saw doctors living where patients were, even in deprived areas. There is something happened to the medical profession where it has, kind of, moved away from where patients actually are. It is more marked in London, but it is happening in other parts of the country as well. Therefore the need to improve access, and sure that we have the right people coming into medicine in the future is very important.

I think there was a watershed around about 1970. Many of us who came into medicine prior to 1970 were as thick as mince, but somewhere after 1970 you had to be increasingly bright; not just intellectually bright, but you had to be able to play the violin to grade VIII, sing in a choir and all that stuff. Now you have these wonderful people coming into medicine, but they are largely from middle class areas. Increasing and widening access is going to be increasingly important. That will mean not necessarily going down market, but simply looking at a person's ability to benefit from a medical education. So instead of looking back at A' level results which have already achieved, and will have been influenced by a person's background, we should be looking forward, as some of the American universities are, our own university is and Newcastle and others, to try to devise tests which will allow potential students to try to problem solve and see how best they would benefit from a medical education looking forward, rather than looking back. If you do that, perhaps you will get rid of some of the biases that our current interview system produces. Even if you go out and say that people should have other things, such as music, or working in the community, perhaps in old folks homes, you are, inadvertently introducing bias against other groups in this county, whose family habits simply make these things more difficult. So there are certain sectors of our society that simply would not let their children behave in those ways for whatever reason. So as you try to open access one way, you may quite inadvertently be biasing against others in another way. We need to think in a much more open-minded way about how we pick people for medicine.

The universities themselves have a huge bias against doing anything useful in this regard. Most of them are recent converts to health being anything important other than for research purposes. The 'Russell Group' of universities, the top seventeen universities, all have medical schools with the exception of Warwick although Warwick now has a medical school, are a very conservative group. Against that you have an NHS which is stimulating innovation and curricular development. 'Tomorrow's Doctors' did not ever come from the academic members of the medical fraternity but from people in the NHS who wanted to see change in medical teaching. Universities are seen by many in Government as so to react, dominated by research and far more interested in the academic pursuit than patient care and fitness to practise. Many of the people in influential positions in Government departments and the Treasury were, themselves, students in the 1960s and still have the fond belief that academics come in at about 10:30am and go home to mow their lawns at about 2:30pm, which is only partially true.

If we look at medical schools, it is actually very difficult to know what a medical school now is, or indeed where it is. It is longer, the big fortress teaching hospital that it was because students are now spread out into all hospitals, spread out into social services and spread out as

part of the community so that, suddenly the medical school no longer exists in the way that many of us see it. It is going to become much more integrated into a local community or local health economy or whatever the in phrase is. Of course medical students themselves are no longer going to be the isolated minority that they were when many of us went through; they are going to be part of a multi-facultied university, they are going to be taught with other students and we are going to be, I think, much the better for it. This is particularly a London problem and particularly an English problem. Of course the London teaching was established in hospitals and not in Universities; it is only fairly recently that the London teaching hospitals have become affiliated to universities. In more enlightened parts of the Kingdom, medical schools are always part of the universities, going back four or five hundred years. I think students probably do benefit from that.

We need to move away from the biomedical model. Of course biomedical sciences are going to be important in the years ahead, but so are many of the social sciences. The qualitative aspects of research are going to be important here, the ethical issues as well as, and not instead of, the biosciences.

So what about the future? The GMC, if it exists, and another body of the GMC goes, will have to set standards. Somebody, and that body will have to include lay people as well as professionals, will have to set the standards. Presumably then, we seek to educate professionals to those standards. And somebody has got to prosecute and then penalise the small minority of people who fail to maintain those standards. And you can either prosecute, or you can penalise, but you cannot do both. You have got to decide what it is that you are going to do and then you have got to decide how you are going to do it. To the best of your ability.

### **Management of medical education**

If you look at our educational future, I think we are going to see four groupings established. I think we will see an undergraduate group, which will take people from point zero, although increasingly fewer people will come in at point zero but will be transferring from other healthcare professions, into the senior clinical years with increasing patient contact. Then there will be a new group which will bring together the senior undergraduate years and the PRHO year and whatever we eventually decide to do about SHOs. That seems to me to be a group, which I have called 'the middle years', though I have no doubt there is a better name for it, and it seems to me that there is a real entity within there that we could actually get a great deal more use from. We could see how skills could develop and extend from the senior years of the undergraduate course through the PRHO year and then into a genuine SHO grade that provided training. SpR probably needs to change very little, i.e. the colleges need to be improved, and then we need to do something much more radical with continuing professional development. So I see four groups being developed, either through the GMC or through some other body.

When you look at those groups, they will have different compositions. The group looking at the genuine undergraduate curriculum will be quite different from the group looking at CPD. There will have to be some sort of link and there has got to be some kind of read through: there has got to be some relevance to CPD from the undergraduate years. There has got to be coherence across the educational spectrum and we need to link very much more closely with the other health professions that we have done in the past.

### **Professionally-led regulation**

If we believe in professional regulation, I think that at best it can only be professionally led and not self-regulation as we perhaps knew it in the past. It is under increasing scrutiny and that is not going to go away. It is fiendishly expensive and it is going to become more expensive as these complaints come through. It is difficult to know whether the profession will want to pick up the bill for all of that. So are there other models that we can look at, and if there are, where are they? The model which the Government is moving towards, with its Medical Education Standards Board, is very much the Eastern European model. I.e. a Department of Health organises the education and training of its own workforce and you get this slightly incestuous circle where, in the past in other countries, standards have been driven down and not up. So I think that we need to keep a very careful eye on that and we need to be aware that regulation and scrutiny on us as a profession is going to increase and it is not just from the GMC but from CHI and NCAA and all the other Government-inspired organisations.

Does this matter? Well it may matter. It may matter to you as well, because the culture of medicine is changing and it is changing comparatively rapidly. If I think back over my years, having qualified in 1969, nothing very much happened for the first twenty years, I would guess but a great deal seems to have happened over the last five or six years and I think that rate of change is going to increase. GLADD has obviously got real concerns about the way things currently are, with several references in your literature to what medical school deans should be doing, how the curriculum should change, what the GMC should be doing to help. My question to you is: what do you actually want us to do? What do you want the deans, either undergraduate or postgraduate to do? Because I suspect many of us would be willing to listen to whatever it is you think we should be doing and are somewhat not sure what we should be at.

I will finish on the note I started off with. Peter King had the vision to challenge the existing order when he was alive. He had the ability to bring people together. He brought together friends, but also people with the ability to form an organisation like GLADD. And he had personal courage and charisma, a love of life and he has left, I think, a fairly lasting legacy. Above all, he displayed that really endearing quality of a complete lack of caution. I will finish with one of the poems that I enjoy by WH Auden; it simply says:

The sense of danger must not disappear  
The way ahead is short and steep  
However gradual it appears from here  
Look if you like  
But you will have to leap

## Questions

I am a mature student with finals in about four weeks time and a background in nursing. I am forever being told that I am part of a multi-disciplinary team, but I am interested to know what the professions allied to medicine and nursing think about us coming into their ranks to be trained.

GC: Some of them see this as a quick route into medicine for them. Medicine is still seen as the upper echelons, and people are talking about an escalator – how you can get on to the escalator at a lower level in health and move up if that is what you want to do. But it is still seen that the consultant, or the principal in general practice, is seen as the ultimate accolade. I suppose that, in terms of job security and income, that is probably the case. They see this as an escape route from the drudgery of whatever job they actually end up doing. Those of us who are in medicine are not quite sure where the drudgery lies, but that is another issue. More importantly, I think, is that, if we are going to have true multi-disciplinary education, what does it mean and how are we going to do it? There are several models in different countries. The one that ministers here like is the St. George's model, i.e. you put everyone together in a common foundation programme, you educate them for ten weeks or longer with the same lectures and the same teaching experience. Some go on to become medics and some go on to other jobs. That's the European system as well. I hope I am right in saying that that model is now beginning to fall from favour. It has all sorts of problems – you don't have people with similar aims, similar background, educational attainment and so on. If you look at the assessment on the St. George's course, you find that it worked surprisingly well at a social level in that the students and that staff liked it, but at an educational level it did not work very well. The groups that did well were the medics and the physiotherapists and the groups which did badly, by and large, were the radiography students and one or two of the other allied health professions. I think what any of us are working towards now is a much more sophisticated system where you get shared learning where that would be helpful, something along the lines of the Southampton model. For example in prescribing, you could have quite a useful session for the pharmacy students, the nurses and the medics. I think it is likely to be round specific skills. From my own background, the most enjoyable experience I had in this was when I used to run a renal unit which was entirely multi-disciplinary, with nurses, medics, dieticians, etc., all working together. We used to have a Wednesday afternoon which was devoted to multi-disciplinary training, but it was absolutely focussed practical issues – what do you do for patients with chronic renal failure or how do you organise a dialysis unit for example. So I think that that is the way forward and that what the other professions get out of it is the ability to see that they might

be a doctor one day and to realise that doctors are different from the rest of healthcare workers, but just perhaps more arrogant and difficult to get on with.

It is clear that the GMC is addressing what the public see as, and what probably genuinely are problems, with the medical profession, but how are you going to persuade the public, perhaps with a somewhat negative Press?

GC: I don't know how you do that. Things are going to get worse. I thought perhaps we were dealing with a backlog of cases and that once we got over the backlog that we would get into the younger consultants and doctors and therefore the problems would diminish. That is, sadly, not the case. There is a whole series of potentially very high profile cases coming up within the next year, which are going to capture just exactly the same headlines. When Bevan introduced the health service, he thought that poor health would get less. I thought perhaps that poor conduct would get less, but our tolerance of poor conduct has got less instead, and therefore we will see poor conduct very much more frequently in the future than we have done in the past. I think we are beginning to see this not just in medicine, but in all professions. We are beginning to see it in MPs' behaviour, lawyers' behaviour, journalists' behaviour: public tolerance of that kind of behaviour is going to diminish. So I think the future for medicine will be that we won't be seen as different any more. We will simply be seen as being like everybody else, with a small number, but not a very small number, of 'bad eggs'. The GMC used to think it was about two per cent but it would appear that it is about five per cent. Of course we do not deal with the grey areas, that is that many of the cases which come to the GMC may not go to Conduct or Performance but they do indicate pretty shoddy behaviour that is not being picked up. There may be a need to do something about that as well.

Speaking as a non-clinician, working for South Thames Deanery, I wondered what your view is about the role of, say Chief Executives of NHS Trusts, in all of this, because I can't believe and I don't believe that it is possible to have anyone in any profession, particularly in a relatively small place, who is consistently performing inadequately, whether on a clinical or inter-personal level, and you don't know. It surprised me that the Chief Executives are not picking up more of this work.

GC: There are two issues there. One is that almost all of the cases that have been sent to the GMC, it has been known. Ask anyone in a hospital who is not pulling their weight or who is dangerous and ask any doctor who they themselves are going to go to, then they know the answer already. So these things are well known. But what happens is that, because of the pressures which the Chief Executives are under, it suits them to turn a blind eye as long as that person is piling through the work, then it doesn't matter too much if the inter-personal skills are a bit ropey. What is very clear is that, if you as a doctor are up before the GMC, very few managers are there backing you up and saying 'it's our fault – we pushed him/her too far' and you really are on your own. In the Bristol Inquiry, the manager there was medically qualified. He argued that he should not have been brought before the GMC because it was in his capacity as Chief Executive that he was involved and not in his capacity as a doctor. The Court of Appeal argued that if you are a doctor, you are always a doctor and you cannot pick and choose when you wear the doctor's hat, so he was still liable, as a doctor, for his actions. This means that the standards are different for medically-qualified manager and we would hope that managers who are not medically qualified would reach at least the same standards. Of course the managers do not get the same publicity but you will often find that they disappear from post after these events. Although people are working to try to eradicate the blame culture in the NHS, it is still alive and well at the present time so it is a brave person who puts their hand up and admits they have made a mistake.

I wanted to go back to multi-disciplinary education and wondered whether you saw any trend in having a university education before embarking on an undergraduate medical training?

GC: I did a lot of my training in the USA and I am absolutely totally signed up to that as a concept. I think the American system where you have a primary qualification first and go into medicine second is absolutely the way we should go and Australia, as you know, has followed

suit very quickly and very successfully. A lot of us think that, at an undergraduate level, what we are doing and should be doing in the medical schools, is nothing and trying to do as little harm as possible to allow people to grow up to become reasonable doctors. The difficulty is that your total cost rises and your time to get somebody through rises. Many of the bids for this round of increased medical student numbers relate to graduate entry and it will be interesting to see if there is a market for that and how many existing graduates want to come into medicine, and whether this will produce the kind of graduate that we want. In the past, these people have nearly always come from the biomedical sciences, but people are beginning to move away from that now, but this would mean that the educational component in these medical schools is going to have to be very much more flexible and therefore also very much more costly.

Do you think that the GMC's role might be enhanced if there might be some mechanism for actually supporting doctors who are doing well and even, dare I say it, praising them? It seems to me that the GMC is very much in the regulatory, punitive and disciplinary role. I realise that that is all because of acts of Parliament, but it just worries me that I do not quite know who it is who smiles on the medical profession once in a while?

GC: We must get the fitness to practise part of the GMC organised so it is efficient, routine, dealt with and out of the way. There is no excuse for rotten doctors and there is no excuse for having to wait eighteen months to have your case answered. There is no excuse for having the lack of consistency in sentencing that we have got at the present time. Until we deal with that, neither the public or the politicians will leave us alone. So I think we need to do that and get rid of it, because we are never going to get any good press for dealing with duff doctors. There is mileage in getting the educational parts right, getting the standards right and getting the public involved. I think the way to get the profession smiling a bit more is to see the postgraduate training much better organised. Most young doctors in training are absolutely disaffected because they don't know what the future is, they don't know that the exams are reasonable and they cannot see a career progression for them. As the Government pumps in money and also the expansion of either GP numbers or hospital doctors, we should be able to get the training organised so that, as in the USA, if you go into the profession, you know you are going to end up with a reasonable job. You may not know where that job will be but you know you are going to get it. I think that the royal colleges will have to get their acts together very quickly and I have no doubt that the Medical Education Standards Board, if it does nothing else, will ask for that. Until comparatively recently, the GMC used to keep a record of the pass marks, not just from the undergraduate medical schools, but also from the different colleges; we stopped doing this some years ago, but the Government has now been asking the royal colleges for this information. The colleges have been extremely reluctant to provide that information and, as you might expect, there is absolutely no consistency whatsoever from one college to another. With one or two exceptions, the exams are not well-based and are not auditable. The discrepancy between pass marks for different groups of doctors is really indefensible. If the PLAB test was a huge embarrassment two or three years ago, then the college exams, if we knew the figures, would probably have the same level of embarrassment and probably the same level of discrimination.

You asked what deans should do. I suppose we are talking about this culture of blame moving to one of support and respect for others. How to we instil respect for others in the doctors in the future and how do we measure that we are achieving this? I think there is also the attitudes of medical schools which need measuring as there are often some students who are struggling who are not picked up and supported by their medical school and take some of their difficulties with them when they do qualify.

GC: Medical schools are going to change, though it will take time. Medical schools need to take attitudes into account right from year one. But assessing performance rather than knowledge, as we do now, is quite a different and more sophisticated process. It is not too difficult to measure knowledge but it is quite difficult to measure all of the other things that are important to making up a good doctor. That is partly why the GMC procedures cost so much. But we do

need to move in that direction, from year one and preferably from before people enter medical school.

Some of these answers as to how to assess attitude are out there in some of the disaffected groups. We have all sorts of effective ways of letting people, colleagues, students, know what we think of the way we are doing things.

GC: You are absolutely right. But you know that people like me have never had that kind of feedback; I have been appraised in my university post for the last ten years and I was appraised when I was a health service manager, but that was largely appraisal on performance, not really on attitudes and nobody has ever taken me aside and said "well maybe that wasn't really a terribly funny joke" or "maybe that wasn't the best way to approach that particular individual". I think as a profession we have been very very slow to do things like that.

You said something about, the way things are going, we are just going to be like everyone else and won't be different any more. This just rang some alarm bells in my head because I don't think that that is the way that it is or should be. I think the power of healing that the placebo effect and trust and faith may be very old fashioned but I don't think that the vulnerability and fears that a patient comes along with can be dealt with effectively without these things and I would be wary of us becoming the same as everybody else.

GC: I think that the respect that you gain will be because of the skills that you have, and the service that you are able to give to others, and not just because of the position that you hold. I think one of the problems with medicine is that it is a bit like the army and is bedevilled by grades, so you are an SHO and you see yourself in that light. I went to look at how they organise acute services in Germany and I went to see an ambulatory care centre in Mannheim. On a Thursday morning they see patients with back ache, so all the patients with back ache are seen by somebody with a knowledge or interest in sore backs, so staff were not identified as consultant rheumatologist, physiotherapist, orthopaedic surgeon, you saw the first person available and if they weren't appropriate for your care, you were passed next door to the right person. You got properly investigated and results back that day and if you needed microsurgery you had it that afternoon. That worked partly because the grading was gone and you were in that clinic because of your skills in back ache. Somehow we need to move part of the way towards a similar system over here. Although I quite like the royal colleges, the system in this country is all wrong. The public don't care whether you are an orthopaedic surgeon, they want to know what you can do for a sore back, so our system with crafts seems terribly out of date and I think in the future we will be known for what we can do rather than which college we belong to.

Instilling respect for others is certainly something my medical schools says it does, but my impression is that once you are through the front door and as long as you do reasonably well academically, developing and assessing appropriate attitudes seems to be rather forgotten about. I wonder whether this is likely to change in the future.

GC: That will change. In this country, when you graduate, you automatically get provisional registration to practise on patients; there is no step. Medical graduation equals provisional registration with the GMC and access to patients. In the past, most medical schools and universities have only been able to disbar students on academic grounds, but in the next few months, there will be clear guidance from the GMC and the Departments of Health to say that there will need to be local fitness to practise committees at an undergraduate level and PRHO level which allow people to be identified who either need to be removed from medicine or in some way helped to get round these problems. This will be separate from the educational component. It has been a huge weakness, especially for the bigger and more prestigious universities, but we are addressing this.

I should just like to mention that in South Thames we do offer to sit in with consultants and watch them working in their own environment working with patients and colleagues, as well as teaching. We keep a

record and when both parties are satisfied that the standard of teaching is fine, they get a Deanery certificate in teaching. I am sure we would welcome your participation in this scheme.

GC: I have been approached to do this. The difficulty is that it is still a voluntary scheme and maybe the people who do not volunteer are the people you would most wish to get participating.

Huw Owen-Reece closed the meeting by thanking Professor Catto for a fascinating and enlightening talk.