Physicians—practicalities, problems and perspectives

On Wednesday 6 July 1994 the College held a successful conference on the principal issues currently before physicians. Despite industrial action on the railways, attendance was excellent. Indeed it might have been difficult to accommodate all delegates if the trains had been running! The conference formed part of a College Day which included the first annual Comitia for Fellows, a discussion led by members of the Standing Committee of Members and a major lecture of general interest.

The training and certification of specialists

The plans

Dr Kenneth Calman (Chief Medical Officer) gave the opening address and discussed a range of issues relating to the report on UK specialist training. A properly planned and carefully conducted scheme of medical education has long been held to be the foundation of a successful health service. The report Hospital doctors—training for the future appeared in April 1993 and dealt with postgraduate training, the amalgamation of registrar and senior registrar posts into one combined training grade and the need for competitive entry into that training grade and envisaged assessment of competence at the end of training. His brief had been to consider the relationship between present UK arrangements and European Union (EU) law, to look for a harmonisation between the two and to prepare a report within six months. Three subgroups were set up to look at specialist training, the UK contribution to developing EU legislation on medical training, and to ensure that the appointment of consultants was compatible with EU legislation.

Dr Calman sought to correct various misconceptions about the scheme. He emphasised that the length of training was a minimum, not a maximum and that it could be varied by the Colleges in the light of their advice.

The essentials of the plan are that specialist training should form part of continuing medical education (CME), that standards have to be met in order to improve training and the clinical service, and that any assessment of doctors’ training will be based on their clinical competence. A certificate of completion of specialist training (CCST) will be issued by the General Medical Council on the advice of the Medical

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Royal Colleges. This would ensure competence, be compatible with independent practice and make the holder eligible to be considered for appointment to a consultant post. Dr Calman pointed out that trainees, on achieving their CCST, would have a period of funding beyond this. This was still being discussed.

Organised and structured training programmes will be required, with the Medical Royal Colleges responsible both for their content and for maintaining standards. Postgraduate deans and Medical Royal Colleges are to implement such schemes, which should be as flexible as possible, by the end of 1995.

Dr Calman emphasised that the plans did not automatically mean fewer junior staff. The number of junior staff required will vary in different specialties according to the number of consultants needed. Entry into the unified training grade will be competitive and judging the required experience for the CCST designation will be a College responsibility. The initials ‘CT’ in the medical register will indicate possession of the certificate. The plan has implications for both postgraduate and undergraduate education, for the NHS and for our relationship with Europe. Dr Calman is aware that the constraints of the new deal on doctors' hours, the plans for achieving a balance and the programme for specialist training are in conflict at times. Follow-up work is needed in the areas of academic medicine, overseas doctors and general practice. The legal framework to support these changes is complex and is still being discussed. He hopes that the scheme for CCST accreditation would be in place by September 1994, to be marked by the designation ‘CT’ in the medical register by January 1995. Structuring the unified training grade and designing a core curriculum were fairly straightforward but mapping out the terms and conditions of service and the necessary appeals procedures were more complex. A national training number will be needed to identify people within the training scheme and to follow their progress. The number of posts will need adjustment by specialty, some requiring more junior staffing and others more consultants.

The SHO grade is secure and forms the foundation of entry to the unified training grade. Further thought is needed about the future of the consultant grade, particularly in relation to CME and patterns of work. If appointments were made earlier, doctors would be in a consultant post for considerably longer and would need opportunities for career development. The style of consultant work would also need review. College representatives would still have an important advisory role in consultant appointment procedures, allowing the Colleges to exercise their important role of quality control in this area. It was vital that the purchaser-provider split did not lead to any imbalances in education and manpower considerations; a new national group would be needed to oversee those matters. The plans for implementation of the report (by the end of 1995) were on time.

The implementation

Professor Brian Pentecost (Linacre Fellow, Royal College of Physicians) spoke on the implementation of the plan. Colleges have responsibility for training through the Joint Committee on Higher Medical Training (JCHMT) which has 24 specialty advisory committees (SACs) and runs 45 training programmes. All specialties recognise the need for a period of general professional training at SHO level, usually a two year integrated programme, and most require an entry diploma such as MRCP or equivalent. SHOs should remain pluripotential, so their training should be wide and not solely aimed at passing the MRCP examination or its equivalent.

The duration and supervision of higher medical training are College responsibilities. The minimum length of training is four years in the specialty. There should be a programme director or mentor who is not involved in day to day training. The curricula devised by the SACs vary in details, such as the number of skills and areas of knowledge to be mastered. Assessment is a new and important feature of training and was discussed in detail. Research is accepted as an important and integral part of any training scheme, although direct 'hands on' research is not essential in all specialties.

A new feature of training will be the annual formal assessment of trainees. This should be undertaken away from the work place and will not involve an exit examination as this would be unrealistic and unworkable when dealing with 45 individual training programmes. The assessment panel consists of the postgraduate dean and the programme director, and is chaired by the College regional adviser. On at least one occasion the panel would be joined by a specialist nominated by the JCHMT from another region. Documentation will consist of an open report on the individual from the trainer and a written record of training maintained by the trainee in the form of a specialty log book. A report to the JCHMT from the postgraduate dean at the end of training and a subsequent report from the JCHMT to the GMC will result in the award of the CCST.

The maximum educational credit for research will be one year in four years of higher medical training. Longer periods in research would still require the balance of training to be completed. However, it will be possible prospectively to negotiate additional clinical credit for longer periods of research.

Dr Pentecost felt that part-time training should be more flexible as half-time working really meant working considerably more than half the hours of a whole time equivalent, particularly when on call. This aspect would need to be negotiated with the rest of Europe as the EU currently requires twice the length of training for a half-time appointee.

A scheme for higher medical training in general (internal) medicine with a specialty envisages spend-
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...two years as an SHO to gain the MRCP, followed by one year in general (internal) medicine with a specialty during which a trainee will be resident on call four nights per month with continuing care. This will be followed by two years whole time in a specialty and a further two years in general (internal) medicine with a specialty, including 40 nights non-resident emergency work with continuing care.

Supervising consultants will be responsible for the teaching of trainees and the specialist societies will host scientific and training meetings for this purpose.

All senior registrars currently in training will get a national training number. Honorary senior registrars not in approved posts would have to compete for the remaining national training numbers in the national quota. On obtaining a training number those currently in higher medical training will be reviewed by the JCHMT to determine the balance of training required for award of the CCST.

Those currently in the registrar grade will have to compete for the remaining unified training posts and for a national training number, irrespective of previous enrolment for higher medical training. This seems reasonable as they would still have had one more hurdle to surmount—competition to obtain a senior registrar post. The JCHMT may grant retrospective recognition of training at registrar grade on advice from the region. Registrar posts usually filled by candidates without the MRCP will be regraded to SHO; posts usually held by trainees with MRCP will be considered for inclusion in unified training programmes and postgraduate deans will need to rank all current registrar posts and determine those most suitable to provide higher medical training.

This session concluded with questions and answers. European accreditation boards will be kept separate from the CCST arrangements. Dr Calman explained that one could not yet make appointments to the unified training grade as the terms and conditions of service for such posts had not yet been formally agreed. He emphasised that it is necessary to maintain central medical manpower planning. A scheme is required to ensure that the devolved responsibilities of trusts and purchasers do not lead to an imbalance in the number of trainees and consultants. In this respect the Department of Health seeks advice from the colleges. Dr Calman also accepted that consultants will need more time for teaching, audit, management and CME. This would require a review of consultant numbers by specialty as well as different working patterns.

Continuing medical education

British proposals

The session on CME was opened by Dr P Toghill (Director of CME of the Royal College of Physicians). He explained that the scheme was introduced to meet calls for accountability, changes in public expectation about professional competence, political pressures and the need to keep pace with the growth of knowledge. Re-accreditation and re-examination were felt to be cumbersome and impractical but the medical profession has to accept the need for regular appraisal which had been adopted by professions such as law, accountancy and architecture.

The goals of CME are to promote high quality and up to date patient care by ensuring that all clinicians have opportunities to learn and to maintain and improve their competence in practice. The Medical Royal Colleges set up a working party in 1993 to make recommendations about CME which were published in April 1994. CME is a professional obligation on all career grades and is particularly important in the new staff grade. A commitment of 100 hours per year, divided between the local hospital (internal CME) and outside activities (external CME), is envisaged. Balanced individual programmes should follow a five year cycle. The RCP will issue a certificate of participation and keep a register of CME.

Because of mismatching schemes between the three Royal Colleges, their Medical Directors of CME have agreed to a two year introductory phase with a minimum of 50 hours per year, to be increased to 100 hours per year of mixed internal and external CME. The basic unit of CME would be one hour of study. Participation in a study day would gain five hours credit, a half day three hours. Physicians should utilise to the full their annual 10 days study leave.

Internal CME encompasses grand rounds, clinical meetings, journal clubs and interdisciplinary meetings. External CME can include college conferences, national and international specialist societies, meetings at university institutes, regional conferences and regional societies of physicians. Reading scientific journals and writing scientific papers are at present excluded because they are considered impossible to score.

Physicians will keep a record of their own CME and send details to regional advisers who will then pass the physicians’ records to the CME office at the RCP where they will be matched against details of CME events and attendance registers. If a physician’s programme was considered satisfactory this would be recorded in the CME register; an unsatisfactory record would lead to investigation by the CME director and regional adviser who would advise how this could be remedied in the subsequent year.

Regular specialist postgraduate meetings organised by national societies would probably be given blanket approval but some Colleges may charge for approval of postgraduate material contained in one-off meetings. Dr Toghill emphasised that the CME scheme is not a process for identifying and dealing with poor performance. It has no sanctions as the Colleges consider that CME is a professional obligation.

Money will be needed to purchase training and...
physicians will need time to participate. One may hope that purchasers and managers will make money and time available, but it is quite possible that doctors might have to contribute personally, as happened in the legal profession. Dr Toghill ended by saying that no professional could afford to rely solely on experience and all physicians should be confident of their own competence to practise.

The American experience

**Professor F Davidoff** (Senior Vice-president—Education, American College of Physicians) described the American experience with CME. The American scheme had a national governing body and had adopted a credit system focused on the educational process rather than its effectiveness or outcome. Category I credits could be documented and were faculty driven with a group focus (lectures/courses) and learning objectives. Category II encompassed self driven, individually focused and tailored education, including reading and writing scientific papers. Both systems were controlled by the American Medical Association, with category I events receiving higher grading.

Category I credits were tied to State law for relicensing in half the States and were considered in most hospitals when granting admitting rights. Although lectures and other passive forms of learning were the least authenticated methods of improving clinical practice, this form of learning has received undue emphasis because it is easy to document and because of its higher credit rating.

Such systems are expensive. The price was US $0.5 billion per year in direct costs and roughly half this sum came from industrial sources. The real costs of CME were not known as industry often suppressed knowledge of its contribution. A system that depends on industry is inherently unstable. The pharmaceutical industry could exert influence on CME providers so that events might be promotional rather than educational, and could influence the choice of a teaching faculty because of financial connections between individuals and industry. Postgraduate teachers might be unduly influenced by gifts from pharmaceutical companies. These potential conflicts of interest were monitored by the Federal Drug Administration, the American College of Continuing Medical Education and the American Medical Association.

Forces for change are at work, eg Canada has adopted a new approach to CME more concerned with the answers to questions than with time spent on education. It was hoped to produce an active learning programme focused on individual doctors, with documentation in notebook form. The aggregation of such data would need careful assessment but it might be cheaper and less dependent on the pharmaceutical industry. Work is under way on schemes of continued self improvement using practice guidelines, critical pathways or algorithms and evidence based information.

The aim is to shift the focus of CME beyond knowledge to the application of clinical skill. Written and computer based interactive self-assessment programmes suggest a way for the future.

Future measures of educational effectiveness will have to be based on changes in clinical practice or outcomes of management. Physicians will have to keep portfolios, and learners could make commitments for change which would be reviewed later. Certification boards were switching to limited (five to ten years) rather than lifelong certification. The precise nature of the re-certification process was still uncertain but strengthened the need for improvements in CME. The Accreditation Council for CME is undergoing a process of self-examination to meet these pressures. Dr Davidoff concluded by mentioning the possible impact of USA health care reforms. There might be future pressures on funding from the pharmaceutical industry and more demand for efficiency and effectiveness in CME as in clinical care.

General discussion on CME

Contributions included the importance of adding assessment of the quality of CME and the impact of computer based programmes and compact disc information systems. One questioner expressed the view that our CME programme was one for the 1970s rather than the 1990s, being based on hours spent rather than proof of improvement. Dr Toghill reminded the audience that the current scheme was an initial step and that there would be further refinement and development. If CME is to proceed purchasers will have to be convinced that they should support it with adequate funding.

Changing patterns of care

*Health economics and the arguments for reform*

The afternoon session opened with a talk by **Professor Sir Duncan Nichol** (formerly NHS Chief Executive and now Head of the Centre for International Healthcare Management). Sir Duncan outlined the desirable features for systems of health care: they should be equitable, accessible to all, responsive to patients, delivered at affordable costs, and efficient. He detected a sense of convergence between private and public health care systems. The private system based on healthcare insurance was highly responsive to choice by the individual but did not provide access for all. The old public NHS system allowed good access and universal cover but tended to neglect the question of individual choice and suffered from variations in efficiency between providers.

The new public NHS system of competition through an internal market has to be managed to ensure conformity with government priorities, the availability of core services, the preservation of research and avoid-
ance of cost fixing by providers. It requires a system for arbitration in disputes. All countries face the problem of growing demand for health services from limited resources. This gap could be bridged by greater clinical effectiveness, greater efficiency, additional resources or reduced demand. It was most unlikely that additional resources would be made available. Sir Duncan presented data from the World Bank report of 1993 relating deviations from predicted life expectation to deviations from predicted per capita expenditure on health. Life expectation was no better in certain countries with greater expenditure. Consequently, it was difficult to persuade government to spend more on health. There might, however, be arguments for selective funds tied to specific health gain: if the aim is to improve indicators of national health perhaps more should be spent on social services and housing than on health alone.

The demand for health care services could be reduced by introducing co-payments or charges for health care. They would certainly reduce demand but would be unacceptable because those with the greatest need would be hardest hit. Rationing of health care is a difficult area. There is an unresolved conflict between utility (the greatest good for the greatest number) and the right of the individual in any rationing process. Governments do not like to adjudicate on this question at a national level but have devolved decision making to local purchasers. The legitimacy of these local decisions has become increasingly important. Choices are complicated by greater consumerism, ie more vocal demands from individual patients. Sir Duncan saw the British scheme as attempting to close the gap between increased demand and finite resources through a logical series of steps to cost effective clinical practice:

- Assess population needs
- Collate evidence on cost effective clinical practice
- Study variation in current provision
- Define priorities for intervention
- Specify objectives, services, standards
- Contract for service
- Audit process
- Audit outcome

The system could be refined by clearly specifying what we are trying to achieve, allowing purchasers and providers to develop a collaborative dialogue, defining criteria of success to improve outcomes and deepen understanding of the relationship between cost and quality. Sir Duncan felt that a single integrated budget was required encompassing preventive medicine and primary, secondary and tertiary care. Our present system had a perverse stimulus to shift cost from one area to another. The aim should be to promote an integrated healthcare system and reduce fragmentation between the present discrete parts of the NHS.

Sir Duncan presented early work from the USA on the opportunity to address health care costs for each disease from prevention through to tertiary care. Management could be exercised on either an episodic care or total care basis. The episodic care approach was to break down the costs of health care into items such as hospital expenditure, drug expenditure etc, and manage each individually. In contrast, the total care approach was to scrutinise the total costs of health care for each disease, find opportunities to rearrange the pattern of management of the disease and use those opportunities to save costs in treating the disease within a population. An understanding of the disease process was essential for collaborative purchasing and fitted better with this emerging system of managed care in the USA than with the present system of managed competition in the UK.

The primary/secondary interface

Professor Roger Jones (Wolfson Professor of General Practice, United Medical and Dental Schools of Guy's and St Thomas' Hospitals) opened with an account of research and development priorities in this area. Topics for research should relate to NHS need, be likely to benefit the NHS and patient care, be relevant to policy initiatives and reflect the burden of disease. The project should result in lower costs or/and better services to patients. It should be feasible and likely to be implemented. Variation in practice was an appropriate subject for research.

The interface consists of the general practitioner, the primary health care team and the community medical services on the one hand and the hospital specialists, the hospital team and the hospital medical services on the other. Entry from primary to secondary care occurs by referral to the outpatient department or to open access services or by admission for emergency or specialist care. Future trends in primary and secondary care envisaged less inpatient care, less hospital based outpatient care, more integrated care in the community, a greater use of outreach clinics and an overall change in traditional roles. Exciting changes affect the exit from secondary care: day surgery and minimally invasive surgery are reducing hospital stay; wider use of discharge advice, care protocols and surveillance schemes and the development of greater support for special groups are increasingly important.

Professor Jones presented data on GP consultations for gastrointestinal symptoms. Ninety five per cent of them did not result in hospital involvement but referral rates for the remaining 5% were idiosyncratic. Even within individual general practices there were wide variations in referral rates although patients had the same demographic characteristics. The range of prescribing also varied in an unexplained fashion. Attempts had been made to address these problems by greater use of guidelines. Paradoxically, in a study at Southampton prescribing costs had risen as a result of
agreed shared care guidelines on the management of dyspepsia.

There are shifts in the balance of care: shared care is increasingly common and specialist outreach clinics raise the possibility of improved transfer of information and skills and better communication. The professional training implications of such clinics are still to be fully considered. Other factors affecting the balance of care are greater GP access to diagnostic facilities, the extension of contracting, purchasing and GP fund holding, and the impact of new technologies.

Current changes pose both threats and opportunities. There are dangers from the contraction of resources and an accelerated change of pace. Purchaser/provider relationships could distort the pattern of care and there is a danger that decisions are sometimes taken in an information vacuum. Nevertheless, there are opportunities for unitary planning or budgeting and increased responsiveness to consumers. Practices could indulge in strategic planning and exert pressure as purchasers to improve services for patients. Overall, these changes have encouraged reappraisal of the balance of care.

The future of specialist medicine

Professor D R London (Registrar, Royal College of Physicians) spoke on the future of specialist medicine. He described the three career grades of consultant, associate specialist and staff grade physician. The consultant would complete a formal training programme leading to the award of a certificate of completion of specialist training (CCST) and take up post after the recommendation of an advisory appointment committee. Associate specialist appointments were made ad personam to doctors who had at least 10 years’ experience after qualification and four years in the staff grade. Staff grade physicians must complete at least three years as an SHO and be appointed on the recommendation of an advisory appointment committee. There is an agreed limit of 10% of the total career grade on the number of staff grade physicians, but this varies from specialty to specialty.

Hospital specialists fall into two categories: the generalists who make up the majority, and the pure specialists who predominate in disciplines such as neurology, genitourinary medicine and dermatology. Generalists are found in almost all hospitals whereas specialists are usually based in larger hospitals. The generalists take part in a general medical ‘take’, receiving unselected emergency admissions, whereas the specialists do not. The generalists provide overall care and have a wide knowledge of medicine although that knowledge is inevitably superficial in some areas. The specialist provides deep and up to date knowledge in a narrower area. A move to a pattern of health care based on specialists, as in the USA, would require a dramatic increase in the number of specialists and much larger district general hospitals. Professor London stressed the importance of maintaining an appropriate balance between specialists and generalists.

Staff grade appointments allow employers to reduce junior doctors’ hours while maintaining a safety net for on-call duties, and to provide routine services such as endoscopy lists. Such posts are suitable for doctors who have failed to advance or deliberately chosen a post with limited responsibility and hours owing to other commitments. However, associate specialists and staff grade physicians should be allowed to re-enter training and progress to a consultant appointment.

Professor London set out criteria for part-time work. It should provide effective use of manpower and equality of opportunity and permit a career combined with other activities. Half the students now entering medical school are women who might wish to interrupt their training to have children and thus seek a part-time post at some point in their career. Other doctors with legitimate distractions would also wish to enter part-time training. There are difficulties in obtaining a part-time post: manpower permission is required from the Department of Health, funding from the postgraduate dean and approval from the relevant Royal College. A complicating factor is the EU directives on the number of hours that must be spent in part-time work; a half-time post would double the length of training. Increased job sharing offers high productivity, flexible hours and mutual support but it is difficult to match doctors in some specialties and locations.

The pattern of specialist medicine will inevitably change because of reallocation of tasks and distribution of services. Many hospital-based medical tasks may be devolved to nurse specialists or to primary care. Some services will be devolved from specialist university hospitals to district general hospitals where costs are lower, and ultimately to outreach clinics and community based services. There is an urgent need to monitor this outward movement of specialist medical services.

Outreach clinics have potential advantages, the first being convenience to patients; such clinics are usually nearer the patients’ home and have shorter waiting times. With the GP present, the exercise could be educational for both doctors but clinics are rarely held as a joint responsibility. Their main disadvantage is inefficient use of the consultant’s time because of travelling and seeing fewer patients per session; further drawbacks are isolation from the hospital and its extensive back-up services, loss of interaction with colleagues and the opportunity to teach and train junior staff. The Colleges have to ensure the quality of appointees to outreach clinics; they should be of the same standard as those holding consultant posts in hospital. There are also economic effects: outreach clinics strip assets from a trust since simple low cost consultations occur in the surgery while the complex, expensive ones are referred to the hospital. Good practice in out-
reach clinics requires that there is a geographic need for them, that the facilities are adequate and that patients are fed in from several practices. To use consultant time efficiently there should be a constraint on the number of such clinics and a defined minimum size. Outreach clinics should be provided or led by consultants and should result from a contract with the trust employing the consultant to reduce the risk of asset stripping. There are alternative ways of increasing interaction between primary and secondary care, including the use of fax, video tape, CD systems and teleconferencing.

The proposals on specialist training have considerable service implications. The shorter, more structured training programme will reduce the time available for service because of protected staff teaching time; so also will a decrease in the number of trainees unless balanced by an increase in career grades. Trainees must be formally taught, not merely marinated in clinical work. Teachers and trainers may have to be diverted from routine clinical work to run the programme successfully. Professor London foresaw an ever increasing workload for consultant physicians, their clinical duties being supplemented by data collection, medical audit, research, supervision of examinations and management in addition to their national and international obligations. The future is demanding and exciting!

Patient autonomy

The afternoon concluded with a talk from Professor Sir Raymond Hoffenberg (Past President of the Royal College of Physicians and Professor of Medical Ethics, University of Queensland) on patient autonomy. Beneficence and non-malevolence are requirements laid down by the Hippocratic oath but there is no historical basis for the concept of patient autonomy. The Nuremberg trials and subsequent emphasis on informed consent in connection with human experimentation laid the foundation for patient autonomy. That concept gained ground in the 1960s as part of the US civil rights movement. It represents a flight from authority and the perceived paternalism of doctors. Clearly, its roots lie in politics rather than philosophy.

In order to exercise patient autonomy the individual must be mentally competent and allowed to choose between alternative effective therapies. Sufficient information should be provided to permit an informed choice and patients should be free to refuse even potentially life saving treatment. It is difficult to judge whether those who are depressed, have fluctuating awareness, are in severe pain or know they are dying, can be truly considered competent to make such decisions. Patients can never be fully informed as they cannot have all the data that are available to a qualified physician. A doctor must act in a way that ‘a reasonable body of physicians would do’. Perhaps there should be similar standards for ‘a reasonable patient’.

Doctors are expected to treat and to recommend treatment after explaining the benefits and risks but only those material to the decision. In the UK, patients have a right to exercise negative autonomy, ie they can refuse any treatment, but do not have the right to positive autonomy, ie the right to demand a specific treatment or procedure. In the USA, doctors consider it a duty to inform a patient of the options available and to leave the decision to the patient. This is in large part dictated by an attempt to reduce the risk of subsequent litigation. Autonomy is an essential principle in the USA and gives the patient the right to demand life support even when a doctor considers it inappropriate; contrarily, demands for euthanasia are also gaining acceptability. Professor Hoffenberg feels that this process has gone too far and is heavily influenced by the need to minimise risks of litigation. Patient autonomy must have its limits.

In the UK the request for patient autonomy is more subdued. In general, the public has confidence in the doctors and there is a stable and mutually respectful system. As most doctors in the UK are salaried, they are not generally regarded as mercenary, whereas the public in the USA is aware that doctors are paid specific fees for carrying out particular procedures. Consequently we have less need to relinquish our role as advisors, and positive autonomy has little place in the UK. Professor Hoffenberg feels that doctors should not hesitate to use their authority for the benefit of their patients; in doing so, they are exercising a benign ‘paternalism’, not an authoritarian ‘paternalism’.

Professor Hoffenberg has grave doubts about the Health Service ‘reforms’. Its new commercialism has led to doubts about the impartiality of medical advice. He is also alarmed at the development of a two tier system, the increased pressure for productivity and consequently a reduction in the time available for advice and counselling. He sees an erosion of the personal component of good practice and warned that the public might come to see the providers of health care as increasingly mechanistic, commercial and avaricious, as in the USA. Both doctors and patients have a common interest in putting patients’ best interests as their first priority.

General comments

Questions from the floor showed a range of reactions to the programme. Some consultants saw the changes in the NHS as exciting while others envisaged a depressing time ahead. Concern was expressed about the change in work pattern for consultants and the dramatically increased demands on their time. Some argued for a ‘new deal’ for consultants. Dr Calman assured us that the changes would be implemented gradually and that more consultant staff would be
appointed. One questioner expressed anxiety that doctors in training did not wish to take on either the life style or the duties of a consultant. Professor Jones felt that the enthusiasm of trainees varied irrespective of events. The President of the Royal College of Physicians said that work studies are still under way to determine what should be a reasonable work load for a consultant.

Some saw a risk from the merging of purchasing authorities into larger units with still greater powers. Concern was also expressed that the 'reforms' had been introduced without adequate consultation or research and were still tentative after four years of implementation. There was also anxiety about the magnitude of change and its effects on the workload of general practitioners, particularly the early discharge of patients from hospital after minimally invasive surgery. Further research is needed on the optimal use of general practitioners' time as well as the work patterns of consultants. Professor Jones warned that seamless primary/secondary care could be more expensive than the present system. There was interest in the future of community hospitals and their impact on patient choice when patients become free to choose their point of access to health care and might choose to see nursing or paramedical personnel rather than physicians.

In a discussion of the costs of health care, Sir Duncan acknowledged that these were modest in the UK because of low pay levels arising out of central pay bargaining, the gate-keeping role of the primary care system and the tight control that had been exercised over clinical manpower.

Report of meeting with representatives of the Standing Committee of Members

The Members conducted a lively discussion led by Dr J Ahlquist (past chairman of the Standing Committee of Members of the Royal College of Physicians) entitled ‘What should the College be doing for its Members?’ The College welcomes Members’ views and comments and recognises that they have hitherto been kept insufficiently informed of College activities. The workings of the Standing Committee of Members (SCM) were explained, in particular its role in representing the interests of the 6,000 or so Collegiate Members. During the past year the SCM had informed the College on Members’ opinions concerning the Calman report, the MRCP exam, the role of the pre-interview visit and the need for associate College tutors.

The network of associate tutors was a welcome innovation and deserved further implementation—100 are now in post throughout the country. But concern was expressed that their duties and those of the College tutors were increasingly confined to acute trust hospitals rather than given to the district as a whole; moreover, the role of the College tutor was not always fully understood by junior medical staff; a situation that could be improved by a clearer job description and better advertising at local level.

Members praised the journalistic style of the College News & Views and also welcomed direct communication from the President concerning important issues such as progress with implementation of the Calman report. There was a strong view that the College should do more to represent and inform young physicians in training (pre-MRCP) who are not yet eligible for Collegiate Membership. A form of associate Membership was strongly recommended and the SCM will take this issue further.

Dr Ahlquist repeated the College’s wish to be apprised of its Members’ opinions and ideas and urged all Members to contribute to current and future debates through the SCM.

The challenge of change

Professor Charles Handy (Visiting Professor, London Business School) gave a College lecture on the challenge of change. He was worried that the Health Service was now seeking to apply the lessons that the rest of the business world had already discarded. Economic rationalism was not sufficient in that it bred only a commitment to itself. The business community was seeking the sense of mission and commitment to others that the Health Service already possessed. He divided his talk into three sections: ‘The challenge of change’, ‘The shapes of change’ and ‘The dilemmas of change’.

Change inevitably represents a profound challenge. One has only to think of the impact of the discovery of the printing press on the dissemination of information. Organisations built as pyramids to ration information could no longer be sustained. Better forms of communication will make the office redundant as many use it only as a place to answer the telephone. The decline of the office would mean that organisations would have to run without meetings. There would be a renaissance but also opportunities for chaos, anarchy and persecution. Management organisations are under the same potential threat as libraries. No longer is it vital to have journals physically present and bound on shelves and for individuals to go to a specific building to seek knowledge. Data can now be accessed from computer terminals many miles distant and the journals printed from a computer disk. Libraries have to change to meet this challenge, as do management organisations.

On the shapes of change, Professor Handy described the S shaped curve as a model for the launch and success of a new product and the pattern of one’s career. It is vital to jump off and start a second curve before the peak and subsequent decline is reached. Organisations have now taken the shape of the shamrock, its three leaves representing the professional core, the contracted-out portion of the work force, and the hired help. Organisations have adopted
the formula of \( \frac{1}{2} \times 2 \times 3 \) to ensure efficiency and productivity, i.e. half as many staff, paid twice as much, but expected to do three times the work. Whereas workers had been expected to accomplish 100,000 hours in 50 years, they now had to complete this work in 30 years. Huge and heavily expensive corporations that aimed to provide every service themselves are a thing of the past. A federal system is needed, centralised as well as decentralised. Organisations require variable geometry rather than a monolithic structure, i.e. they have to be large for some roles such as purchasing but do not have to duplicate this size across the whole range of their activities.

The strengths of professional staff are that they take personal responsibility for their actions (they are prepared to sign their work), set standards and can exercise subsidiarity (make decisions without these being stalled at a higher level). Organisations are now virtual and exist in networks rather than places, and they have to be businesslike, looking at outputs vs inputs. Professor Handy was disappointed to hear that Sir Duncan Nicol had not got round to thinking of this concept in connection with the Health Service.

The dilemmas of change are how to lead from above while managing from below, how to measure success, how to balance security and flexibility and how to prepare for an unknown future. The concept of the manager has been replaced by the team approach of the rowing eight, i.e. small groups built on trust and competence pulling in unison, with different leaders for different tasks.

Business has realised that profit alone is an inadequate measure of success and that a multiple scorecard system is required. Tenure is an outmoded concept and should be replaced by 'employability', i.e. ensuring job security depends on continued learning and training throughout one's working life. Experience has shown that strategic planning rarely bears fruit; instead, one has to create scenarios for a second S curve by developing alternative plans of action in response to outside events. Professor Handy finished by describing a sculpture he had seen on exhibition consisting of an empty raincoat. It reminded him of people he had met within organisations who were merely an empty shell without any inner motivation. He urged his audience to keep its motivation by preserving a commitment to others and a caring approach.

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