Ulster Medical Society

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An Overview of the GMC—Regulating Doctors, Ensuring Good Medical Practice
Professor Sir Peter Rubin
General Medical Council

Dr Cupples:

Good evening, everyone. Thank you for coming, and taking time out of your busy lives, and out of a lovely summer's evening almost, but certainly a very spring, bright evening. We're delighted to have someone here who's going to shed light on medical education and the GMC. We would extend a very, very warm welcome to Professor Sir Peter Rubin, who is the Chair of the GMC, and has a wealth of many interesting activities in his life's work, and I'm sure his life outside of medicine as well, that I know less about, but he is currently the Chair of the GMC. He's also Professor of Therapeutics at Nottingham University, and he's also a consultant physician in Nottingham Hospital.

He works with medical students, he works with doctors, he works with patients, and he works with all sorts of medical people who may or may not cause problems, and not only that, he has also worked with veterinary surgeons over the years, and pharmacists and pharmacologists, so I look forward to hearing what he is going to say this evening, and I would invite him to come and speak to us just now. Thank you very much.

Sir Peter Rubin:

Well, hello everybody, and it's really nice to be back here again. I come to Belfast two or three times a year, or come to Northern Ireland two or three times a year, and it's really nice to be here. This is, I think, unique in my experience, in that it's not rained all day, and it looks very nice in the sunshine, doesn't it?

I'm often told by people, usually of a certain age, that doctors aren't what they used to be, and I'm going to explore this theme with you this evening. It used to be so simple, didn't it?—a doctor was a handsome young man with hair, and nurses were pretty young women who were shorter than doctors, and everyone knew where they stood, didn't they? It was all so straightforward, and then everything went spiralling downhill. This is the BMJ, "The doctor of today, they can't take your history, they can't do a physical examination, and rely entirely on lab results"—booms the BMJ in 1944.

A lot of the people who go on to me about standards are just spiralling down are people of my kind of age. I graduated in 1974, but actually, we, it seems, were rubbish. 1975, the BMJ is concerned about the poor quality of medical students at the point of graduation—that was us, but to understand how really serious things have become, you have to look at this. You really know that the rot has well and truly set in.

So I think, of all the things that I am beaten around the head about, and this was particularly true when I chaired the GMC's education committee, it was anatomy teaching. My goodness, have the standards dropped! You know, the time was when allegedly we could name all those funny little bones in the hand, I never did quite get to grips with. The cartoon I like best about anatomy teaching comes from the Times, which I'll leave you to read yourself, and what prompted this was that a long retired surgeon had primed a couple of journalists from the Today programme to go into St George's Hospital Medical School, and ask students anatomy questions that no right-minded student would know the answer to. If you knew the answer, you were sad, you were reading books or something dangerous like that, and they asked the questions and clearly they didn't know the answers. But actually, you go back, and in 1976 the BMJ is going on about the concern about anatomy teaching in Britain, and going back to 1911, to the Haldane enquiry into the University of London, the great American educational reformer, Abraham Flexner, he was tearing anatomy teaching in the UK to pieces, it was rubbish. So you get these same themes coming up again and again and again, it was all so much better before.

When you try and find the golden age, when things were so much better, is surprisingly elusive, and particularly when you try and find real hard evidence. Some of the best evidence comes from the last royal commission on medical education, which was in the 1960s, 1968, and they did a survey, a very robust survey, of final year medical students in the UK, nearly 2,000 of them. Over 50% were completely hacked off with medicine, and were thinking of not doing medicine as a career, and a third were thinking of leaving the country, and did. Now, whether the same third did, but they did. A really interesting thing happened in the '60s and '70s, Canadian doctors went to America, British doctors went to Canada, Indian and Pakistani doctors came to Britain, and a third, the numerical equivalent of a third, of every graduating class from the UK emigrated. Those were the good old days, that people go on about. When I graduated, doctors were so happy we were going on strike.

Some of you will remember UMTs, units of medical time. Doctors were going on strike, about units of medical time, and I was talking the other day to the annual dinner of the BMA Junior Doctors' Committee, and I was thinking, actually they're pretty tame these days. They think they're strident and active, they're actually pretty tame compared to the way things were back in the '70s, when everyone, of course, was going on strike in the '70s, it was the thing to do, wasn't it?

Then you've got the concerns, again and again, repeated again and again, including very recently, in the correspondence columns of the Times, from certain long-retired people, that doctors of today lack experience, and John Took, in his enquiry into modernising medical careers, was very explicit about this, and was very critical, the lack of flexibility in postgraduate medical training, but John didn't get there

first, strangely enough, and when Sir George Pickering did his survey in 1978, this is when I was, many of you would have been in post-graduate training, we were apparently in a straitjacket, compared to his day. I didn't feel like I was in a straitjacket at all, but that's how he viewed it comparing to his day. Young doctors were so much more experienced back then, and yeah, in some ways, we did. The best definition that I have seen of experience is from a previous council member of the GMC actually, and this is the definition of clinical experience, and of course that goes to the heart of something which is crucial in understanding all the issues around European Working Time Directive and so on, experience and training are simply not the same, and I do not agree with the President of the Royal College of Surgeons of England, who is arguing very strongly that we should go back to very long hours. John Black, in fairness, is not saying we should go back to hopelessly long hours, but the thing is, there is a difference between experience and training. This was first brought home to me in a most stark way, when I went from being a registrar in the NHS in Stoke-on-Trent, where I'd be banging through a trillion patients in the clinic in one room, and the consultant would be banging through a trillion patients in the next room, and we'd be doing it in parallel, and I wasn't being trained, I was seeing lots of patients. I then went to Stanford University in California, as an American Heart Association Fellow, and I did one clinic a week, and this is funny, my career's now gone full circle, because I'm doing one clinic a week; I did one clinic a week in hypertension, and on my first clinic, I pitched up, and the attending physician said to me, "Now Peter," she said, "If you see more than three patients this morning, you've seen too many patients." And she didn't do the first contact, she sat in a little library, so I'd see a patient, the other Fellows were seeing patients. I'd see the patient, take a long time over it, go to the library, talk to her, she would talk me through it, she'd draw my attention to some recent article in the New England Journal, suggest I read this, read that. She would then come back with me to see the patient, who then got what they were paying for, which was the Stanford opinion, and I'd move onto the next patient. I thought wow!—this is training. But there's a difference between experience and training, and of course you need experience, of course you do, but you've got to be trained first, because if you're not, you could be getting experience of doing the wrong thing over and over and over again, and there's a significant difference there, and I think that is so often lost in all the noise around medical education.

Well, on the theme of doctors aren't what they used to be. I think there are certain things that happened in history, which means that doctors are not what they are used to be, in all sorts of ways, and one is the creation of the GMC. You'd expect, doing the job I'm doing, you'd expect me to say the GMC has some passing importance in this, but why do we have a GMC? We kind of take it for granted now, but why do we have it? Well, there were a number of drivers for change in the mid-1800s, a lot of people calling themselves doctor, and they weren't; a lot of people, including the Archbishop of Canterbury, could give a medical degree, and he still can, but we've taken the precaution of not listing it in the Medical Act, but he really genuinely still can, and did, and the most recent was given very, like three or four years ago. There was, in the mid-Victorian era, a lot of advances in science and medical teaching was just not keeping pace, rising liberal sentiments and feelings against monopoly and privilege, and a widespread perception that the medical royal colleges and their presidents were incompetent—not a lot's changed there, then. There were a lot of people who claimed credit for establishing the GMC, but above all else is the founder of The Lancet, Thomas Wakely or Wakley, depending on who you believe. He was a surgeon, and he felt passionately that there should be a medical regulator, passionately. He really had the colleges in his sights, and when asked why he thought there should be a medical regulator, it was to do away with … and that was one of the milder comments he made about the medical royal colleges, but he realised that he was getting nowhere, and he thought, well the only way that I can get what I want is to get inside parliament, not be making a lot of noise outside parliament, so he became an MP, purely to get the GMC. This is a commitment, and he was in parliament, and it was not a rapid business—16 bills, two select committees, over 18 years, so in comparison, the revalidation, we are motoring, we really are moving along, and there are all sorts of reasons why bills would fail and everything. There were two select committees, as I said: the select committee of 1848 lamented that the profession is "Unable to speak with a coherent voice, and that the colleges were failing to provide adequate leadership."

Some of you in the room may think, I've seen those words before somewhere, and you have to wind forward to the select committee enquiry into modernising medical careers, and the secretariat who were supporting that must have thought, hang on a minute—there's one we prepared earlier here, and they said that the profession is unable to speak with a coherent voice, and the college has not provided adequate leadership. When you have an interest in history, it is extraordinary how people are determined to repeat the mistakes of others, over and over again with great determination.

One reason why the bills often fail at the last hurdle is that the Civil Service then, as the Civil Service now, had their own ideas, and they were particularly interested in having a national licensing exam, what they called a "single portal of entry to the medical profession", and it was seen off by an unlikely alliance of Scotland and the medical royal colleges. The principal, it was as strong then as it is now, I think, but the reason it was seen off by this unholy alliance is shown on this graph: Scotland had had medical schools in universities giving degrees for a very long time, and not for the first time and not for the last, the Scots said to the English, we do not want

an English answer to a non-Scottish problem, thank you very much, guys. The colleges, this is a number of docs going, the percentage of docs going onto the medical register, who did so through a University of London degree as distinct from a college licence. In other words, giving a college licence was a nice little earner, and the colleges were not going to get rid of that in a hurry, and so these two, this pincer movement saw off the national exam, and therefore saw off bill after bill after bill, until finally the Prime Minister, in 1858, could not face a 17th bill coming before parliament, and in July of 1858, he banged heads together, and said, "I've had it with this thing, I've had it. Let's just find some compromise and get on with it," and in 1858, the Medical Act was passed, and was duly recorded in the Times of that year, so the object is to establish a register which would distinguish the qualified from the unqualified, and at its heart, that's what we do to this very day, much more sophisticated, but at its heart, "Why are we here?"—that's why we're here, to maintain a register.

Strangely, this was not the top news story of 1858. You might think it would be, wouldn't you? The top news story of 1858 was the number of banks going bust because of dodgy deals in America!—and it got so bad that the Prime Minister and the Governor of the Bank of England decided to leak to the Times a letter written by the Governor to the Prime Minister. Essentially it said "We know that people are worried about the number of banks going bust in England and Scotland," and then it goes on to say, "We, the Bank of England, we'll stand behind the economy basically." Where the Scots get their reputation for financial prudence, I will never know, because then, as now, it was the Scottish banks leading the charge into financial oblivion, and what they were doing was, that unlike Vanderbilt and Stanford, who were investing in railroads that went from where people lived to where they wanted to go, the Scottish banks were investing in railroads that went from where no-one particularly lived to where no-one would want to go, and unlike today where we've got the big banks, there were many, many, many small banks, and they were falling over like dominoes. It dominated the Times, and the archives are available online, that's what I've seen, but it dominated the news in 1857 and 1858, but interestingly, it did not lead to regulation of the banking system, and I had an interesting exchange with the archivist at the Bank of England who's confirmed this, and he said, "Yeah, for all the noise, all the disasters, all the bankruptcies, there was still no appetite for regulating the financial system, because entrepreneurial zeal in the mid-Victorian era was felt to be too important—you shouldn't hold it back," but at the very same time, parliament thought, hang on a minute—-doctors, we'd better make sure doctors are alright—interesting, isn't it?

Since 1858, the GMC has been actively involved in medical education. We were originally called the General Council for Medical Education and Registration—that was our title, and medical education was the thing, and over all these years, each of these years is a year where we published our guidance on medical education, and some of these years are worth just noting: 1867, we actually defined, unintentionally maybe, but defined what is a regulator. The purpose, it said, is "To define minimum standards for the protection of the public", and that is a pretty good definition of a regulator, isn't it?

In 1885, a very important principle was introduced—this one was, here is the curriculum. You know, you'll do the anatomy of the leg, and whatever. In 1885, there was a major policy change which exists to this very day, which is that the regulator sets the overarching principles, and we leave it to the medical schools to decide how to deliver on the outcomes, and it's what I like to call a Rothesay principle, and it is that we say the equivalent of, we want you to get to Rothesay but whether you do it the quick route or the slow route, we're not bothered so much, as long as you get there, and that is the principle that has been there since 1885.

Now, in 1922, the course went up from four years to five years, because there was so much to learn … Tomorrow's Doctors, I'll allude to a bit later, and many many times, the wringing of hands about overcrowding of the medical curriculum. Note, the first time there were worries about overcrowding the medical curriculum was 1885, and it's been a worry ever since.

So I would argue that one reason why doctors are not what they used to be is that actually they are doctors now. Any of us who calls ourselves a doctor, we can do so because we're on the medical register, and that marks us out from those who are not, so yeah, doctors aren't what they used to be.

There's a second reason why doctors aren't what they used to be, and it's to do with this very boring-looking, very grey report of the Interdepartmental Committee of Medical Schools. It doesn't get much more exciting than this, does it? The chairman was a banker, Sir William Goodenough, who was an Oxford history graduate. He joined Barclays Bank straight from university, and stayed there for the whole of his career, and at the time that he chaired this committee, he was the chairman of Barclays Bank Dominion and Colonial Office. One or two of you may even remember that. He was a master of foxhounds, he looks the quintessential establishment gent, doesn't he?—but, behind that waistcoat, beat the heart of a radical, and his report was indeed radical, but to understand quite why he was so successful in coming up with a radical report, you've got to see the context of the time. This was published in 1944, in other words, against the backdrop of the Second World War. The context was developed and provided by Sir William Beveridge. He was a very eminent economist and a civil servant who, at the time of his famous report, was the Master of University College, Oxford. He was very free with his advice to the coalition government, the last coalition government, on the need for social reform, and his advice was not entirely welcomed, and the government did what governments do. They established a committee, they made him the chairman, and they gave him terms of reference so

restrictive that there was no risk of them doing any harm whatsoever, but they underestimated Beveridge enormously. He realised there was a war on, and people's minds were kind of elsewhere, but they also underestimated Beveridge in that he understood the power of the news media, and the mandarins in Whitehall simply did not, and when his report was published, while the intention of the civil service was that it would be greatly accepted and put on a shelf where it would gather dust, people were actually queueing around the block to buy it, so as an attempt to suppress something, it was not exactly a spectacular success, and an opinion poll carried out two weeks after the Beveridge report was published found that 95% of the British population knew of his report, and about 94.5% agreed with its contents, of social reform. But even given the quality and amazing vision of the report, timing is everything, and this report was published in the first week of December 1942. Britain had been at war for three years, it had been a blinding failure, defeat after defeat, and then in November 1942, the British Eighth Army in North Africa, El Alamein, defeated the German army, and the British population, for the first time thought, there will be peace one day, there will be victory, there will be peace, and then they began to say, well, what are we fighting for here then? We're fighting for the education that I never had, the free healthcare that I never had, and this is encapsulated in a cartoon from the Spectator of just before Christmas 1942, where all of this is rolled together, a soldier in the desert, Eighth Army, drinking a toast to Beveridge and his brave new world.

It was against this, and I should say that, when I gave this talk to a lay group who were of advanced years, shall we say, at the end of it, a guy came down to me and he said, "I was a lieutenant in Aden, when this happened, and this was just what my troop said—that's what we were fighting for", a really interesting bit of oral history, so it was against this backdrop that the banker, William Goodenough, was preparing his report on what sort of medical schools do we need post-war to produce doctors for this new visionary National Health Service?—and what Goodenough came up with was absolutely radical, a dramatic reform of the whole system; degrees, not college licences; and to get a sense of, even in 1933 to '37, still most people got onto the register through a conjoint diploma from the colleges, and these provided 50% of college income, so you can imagine what a battle it was to get the college diplomas out and university degrees in.

He also introduced the pre-registration year, professorial appointments in major specialities. He emphasised the need for comprehensive organised postgraduate education. There should be a drastic overhaul of the curriculum, etc., etc., but then you get to the two really big things, about why I think this is why doctors aren't what they used to be.

The first is, medical schools should be co-educational—I mean, we're talking radical here. Medical schools should admit women, to be clear about this, women to medical school, and the sense of the enormity of this is shown in the slide, which is the female medical students in Edinburgh in 1938, and the total number of female medical students from Guy's, Barts, St Mary's—I could go on, but I ran out of space on the slide. This is radical stuff.

The second thing that the banker, William Goodenough, said, unsuitability for a medical career should be the sole barrier to admission to medical school, and combined with the Education Act of 1944, that opened the way for people like me, the first member of my family to go to university, people like me to go to medical school, and a combination of women and lower social class people going to medical school, of course doctors aren't what they used to be, and this report, although like so much, took years to implement, this report has had a dramatic effect on medical education to this very day.

As a medical profession, we're a funny bunch. Individually we're often very innovative, forward-thinking about the latest gizmos. Put us together collectively, and my goodness, are we conservative! The Royal College of Surgeons of England responded to the Goodenough report by saying this, the college responsible for standards: "Let's not have women in the London medical schools." In the same file, in the National Archives in Kew, in the same file, is this wonderful letter, which just exudes pomposity and arrogance. In the same file as this letter, is a shedload of letters from pushy middle-class parents to their MPs, saying, my bright high-achieving daughter did not get into medical school, the rugby-playing dumbo down the road did, what are you, MP, going to do about it?—and when you're an elected MP, it's a bit of a no-brainer, what you're going to do with that electorate, and what the government did was very clever. They said to the London Medical School, "You're independent institutions. You can do what you like, and when you want taxpayers' money again, let us know." Sometimes you don't need complex strategies and working parties, you just get them where you know it's going to … you know.

The GMC itself, there'd been some change. When the council for the GMC considered this watershed report, what did they say? "Let's not be getting into all this change stuff, when medical students of today have, can't write English. Do they know where to put the apostrophe in it?—no, they don't." That is what the council said in response to the Goodenough report. The government couldn't believe it, the file notes, because we lose all this with emails, the little file written notes in the archives is brilliant. It's the 1940 equivalent of, what planet are these guys on? But eventually, in 1946, the GMC were persuaded to go to what they describe, in the minutes of the council, as the new world, and off they go, and they come back with this report to council, and it was all too much bother, all too difficult, and the GMC essentially lost interest in medical education for a good 35, 40 years. It was all too difficult.

But upheaval and change continued, there was a meltdown in relationships between the medical pro-

fession and the GMC in the 1970s, when the GMC introduced an annual retention fee of £2.00, and it was cataclysmic. Thousands of GPs in particular refused to pay, there was a likelihood that the NHS would grind to a halt because the doctors would lose their registration. The government panicked and established a committee of enquiry headed by Alec Meyerson, and this was far-reaching, and amongst other things, said "The council of the GMC has abdicated responsibility for education, there should be a statutory education committee," and also recommended that the GMC should regulate postgraduate medical education. Well, the colleges saw that one off pretty effectively, but a GMC education committee was established, and then began to motor, and published Tomorrow's Doctors which introduced 50 years on, much of what had been recommended in the report of 1944, but actually was introducing stuff that the most progressive medical schools, like Newcastle, like Nottingham, were doing anyway. I think we've got to remember that, this was happening anyway, but Tomorrow's Doctors was another watershed, and another reason why doctors are not what they used to be, because it explicitly said, there's more to medicine than the science. It's about communication, it's about listening, it's about teamworking. It was Tomorrow's Doctors that began to enshrine that in the culture of medical education, and that, in my view, is another reason why doctors aren't what they used to be.

It also introduced a really important concept in medical education. Until that time, there'd still been this mindset that you had to produce the omni-competent independent practitioner. Tomorrow's Doctors finally did away with that, and said, "Okay, we're doing two things here. Of course, we're training people for the horizons we can see, but we're educating them for what we can't see beyond the horizon," and it was very explicit about that, and again introduced the cultural change in medical education.

There's another reason why doctors aren't what they used to be, and it can be summed up in one word, which is "Bristol". This is the front cover of the BMJ in the week in which the GMC professional conduct hearings ended. This is a mum whose baby had died on the operating table in Bristol, standing outside our previous Hallam Street offices, with a little coffin, and Richard Smith, then editor of the BMJ, in his editorial, said "All changed, changed utterly", from a poem by T S Eliot—"All changed, changed utterly. British medicine will be transformed by the Bristol case," and indeed it was. I think when people come to write the history of medicine in the UK in the last 25, 30 years, I think Shipman, Harold Shipman, will be a footnote. That's not to diminish the evil that he did, and let's be clear, Shipman was evil, but Shipman was a psychopathic murderer. I don't think any of us in this room can really relate to the mind of a psychopathic murderer. Bristol was about looking the other way, and we can all relate to that, because we're all human. Which of us in this room has not, at the end of a weekend, least those of us who work in a hospital, at the end of a weekend, which of us hasn't heaved a sigh of relief as some rubbish locum has gone out the door, and we're just so delighted that they won't be in our hospital again. We've been there, haven't we? We've been there, if we're honest about it, we've looked the other way, and Bristol was about looking the other way. I think long before any legislative change happened, Bristol by itself began to change the culture of British medicine, and made it more acceptable to say of a colleague, he or she is not up to it, therefore resulting in doctors not being what they used to be. It led to the GMC proposing revalidation. This is the text from the letter from the then-president to the medical royal colleges and the BMA, basically saying, "We can't go on like this. Professional self-regulation has failed spectacularly," and that was the beginning of revalidation, but another thing that happened post-Bristol, as a consequence of Bristol, was in the Bristol report, was this sentence: "We are not persuaded that to leave the crucial task of approving/supervising postgraduate medical education direct with the royal colleges alone is in the public interest"—pretty damning stuff, and it's there because the Royal College of Surgeons had failed not once, but twice, to identify the problems in Bristol, and the report, in a forensic way, picks apart the amateur nature of the college reports, and that is another consequence of Bristol, that the colleges had their opportunity, they were given an opportunity in the 1990s to get their act together through the STA, and they failed, quite spectacularly failed, and that's what led to PMETB and now the GMC regulating postgraduate medical education—it all came from Bristol, and of course, the colleges didn't like it, did they? One thing that Bristol did was to change the dynamic between the medical profession and the legislature. The colleges reacted very badly to being held to account for what they did, and one reason why they reacted very badly was that when you took the lid off things, you found some quite surprising stuff, and it was a very difficult time, but it was all about autonomy and independence, and no-one actually questioning your right to do things your way, and that has been a fundamental change as well, in terms of, doctors aren't what they used to be.

So, doctors aren't what they used to be, this is a caricature, but we can all, we can see it, can't we? Doctors aren't what they used to be, in many many ways. However, in ending, I would like to argue that, despite all that I've said, and doctors are clearly very different to the way we were, and I think most of those changes are very positive; I would argue that although this guy from 1858, and this young lady from very recently, may seem worlds apart, him with his microscope, her with her imaging stuff, I would argue that actually there are certain fundamentals about medicine which are timeless, and which mean that doctors in some really important ways are just like we've always been, because if you say, what do doctors do?—not, what does an orthopaedic surgeon do, or an anaesthetist do, or a GP do, what do doctors do, whatever speciality they're in? What do we do?—we

synthesise conflicting and incomplete information, to make a diagnosis, but it's conflicting and incomplete information. We have to have the intellect and the experience and the training to synthesise this morass of information, and make sometimes a life-changing judgement on the basis of incomplete and conflicting information, and doctors do it day in, day out, and have always done so. We deal with uncertainty.

I've done my share of writing protocols, I think protocols are great, but patients are so unreasonable, aren't they?—and you get a patient coming in with condition A and condition B, and the protocol for condition A will make condition B worse. Well, you know, there should be a rule against this, shouldn't there?—and so immediately, we're working off protocol, and we work off protocol every day, don't we? It's in the nature of medicine, we work off protocol, and that is what doctors do, we deal with uncertainty. We manage risk. Medicine's a risky business, and that's not said often enough. It's a risky business. One of the worst things we could do as a regulator is to discourage doctors from taking reasonable risks, because there's so many people alive today because doctors took reasonable risks. Everyone must understand the risk, not least of course the patient, but doctors manage risks, and they, in the conversations that I've had with people who, for example, are very keen to introduce airline industry-type checklists, which I'm all in favour of, but the fact is, that as doctors, we knowingly go into a situation that we know is risky. Airline pilots by and large don't. We knowingly go into situations that are risky, knowing that the risk of death if we don't is high, the risk of death if we do is still high, but lower. We manage risk, and doctors have always done this.

Finally, we accept personal responsibility for our actions. Now, I would argue that that is true of medicine down the ages, and that those of us who practise medicine now are merely the custodians of all this. These principles were passed onto us by those that came before us, and we in turn must pass what being a doctor is onto those who come after us.

In ending, my one final slide, in ending, I think this goes to the heart of something that worries me about medical education and curricula—more so postgraduate than undergraduate, but we have got into a situation where we are very focused on achieving competencies, and of course doctors must achieve competencies. It's blindingly obvious that they've got to achieve competencies, but I think, in the focus on achieving competencies, there's a real risk that we forget what doctors do, and I think that, when we think about, well, what footprints do we leave in the sands of time with regard to medical education, I think there's a huge risk that we leave the educational equivalent of knowing the price of everything and the value of nothing, that we produce a bunch of technically competent people who are not doctors, because they don't do these overarching managing risks, dealing with uncertainty, all these overarching things that doctors do, and I feel very strongly that the GMC as regulator of it all now, has a huge role to play in making sure that the essence of a doctor is enshrined in all medical curricula.

So, no, doctors aren't what they used to be in lots of ways, but in some really important ways, doctors are absolutely what they used to be, and long may it remain so. Margaret, thank you very much.

Professor Cupples:

Thank you very much indeed. I think I could speak for everyone to say that was an extremely interesting talk, and certainly doctors aren't what they used to be. They say that general practitioners live in the realm of uncertainty most of the time. Perhaps other doctors do too, what do we think? Questions, I think Sir Peter will be happy to take some? Would anybody like to lead off?

Sir Peter Rubin:

I remember when Margaret asked me to do this, it was made clear to me what she did not want me to talk about, she did not want me to give my usual list to the GMC talk, so I didn't do that.

Professor Cupples:

I heard him speak actually a couple of years ago, and I was quite fascinated by some of the information he gave, about what people thought of doctors, over, the times have changed. John.

Dr John Logan:

This is not really a question, but just could I congratulate both of you, between you, on choosing the subject, and you, Sir Peter, speaking to it in such a way. I very rarely [?] about what doctors do and their responsibility, I've rarely heard it distilled so succinctly, and I think it's absolutely marvellous, and thank you very much.

Sir Peter Rubin:

Thank you very much, thank you.

Dr John Craig:

Yeah, I was going to ask, I'd go exactly with what John has just said, I thought that was a superb talk. One of your slides referred, and it was done around, the infant survival scores might be slightly, very different from what they are now in terms of [?] Does the GMC have a position on the fact that most people that enter into medical school have to pay £9,000 a year to even take a medical degree.

Sir Peter Rubin:

We don't have a formal position on that, because we don't, we have no statutory remit in terms of admissions to medical school, so we're very careful not to get involved in what is clearly a very political argument. As somebody who is a product of the grammar school generation, as I said, the first in my family to go to university, clearly I have personal views on it, and my personal views are that, if we don't ensure that the very brightest young people get the very best university education, we fail not only

them, we fail the country too, and so whatever happens with these and bursaries and scholarships, I personally, and it's not the GMC policy, but personally I think it is absolutely fundamentally important to the future of the country that the brightest young people get the best university education, and I'm not sure that what is happening at the moment is likely necessarily to ensure that.

Professor Cupples:
David?

Professor David Hadden:
Perhaps I should declare a conflict of interest before I ask this question, because I have connections with one of the royal colleges, which I am now retiring from, but I also am a member of this august society which affects everybody, you see it's open to us all, and I go back to a great-grandfather who, before the Medical Act, was an apothecary, in the now disbanded Apothecaries Hall in Dublin, which is in disgrace because it was one of those bad places that didn't teach them properly, and I was delighted, as John has said, in your historical review, because it's most interesting and good for us all, except one thing—you were identifying the progressive medical schools in the 1950s and '60s, and those of us who went to this medical school in Belfast knew, because we always knew, that Belfast was a very progressive medical school in those times.

Sir Peter Rubin:
I stand corrected!

Professor David Hadden:
Long before Nottingham was even thought of. The Professor of Physiology, David Greenfield.

Sir Peter Rubin:
Indeed, he was the Foundation Dean.

Professor David Hadden:
But my question, and it's a serious question, because you dealt with this in a rather light-hearted and a very nice way, is the GMC anti-college?

Sir Peter Rubin:
Oh, no. No. I try to criticise the GMC and the colleges in equal measure, because both were putting their head deeply in the sand, and both were failing to realise the world around them had changed—far from it. My view is that the medical expertise resides within the medical royal colleges. It doesn't reside in the GMC, it resides within the medical royal colleges, and in some specialities, also within the specialists' associations, and you'll be aware that in some specialities, not all, but in some, there's tension between the specialist associations and the relevant royal college.

My wish of the medical royal colleges is that, I think I can say with some certainty that the GMC has reinvented itself in the last ten years or so. We're a very different body to what we were, and I think we've done that because there was a recognition that you either change or you die, and I hope that we're now more attuned to the world around us, while maintaining the core standards.

Now, my concern about the medical royal colleges is that not all of them will do all that is necessary to ensure that they are attuned to the changes in the world around them, and that too many of them will be too anchored to the assumptions of the past, which will not hold true for the future, and I certainly would not want to see the medical royal colleges weakened or diminished. My concern is that postgraduate medical education, I think, is going to become a global market. I think we're going to see providers coming in from outside the UK, offering to produce curricula for major specialities, and exams for major specialities, and I'm concerned that the medical royal colleges should be in a position to maintain the high reputation that they have, not just in the UK but in the world, so no, most definitely we're not anti-college. What I'm saying is that the GMC has moved with the times. Some colleges have, but I think all colleges need to recognise the world is constantly changing.

Professor David Hadden:
Do you think there are too many?

Sir Peter Rubin:
If we were starting now, would we have 17 royal colleges and faculties in the UK alone, not including the Irish colleges, and yet, there has been no reworking. If you look at the way that the Canadians do it, with a couple of overarching organisations with speciality groupings beneath them, there are economies of scale there which are really important. The very large colleges, of which really and truly there are only two really, really big colleges, do have lots of money to do things with, but there's a long tail, and the tail includes colleges that struggle to have the sort of staff that for example, at the GMC, I take for granted. I take for granted the support I get from the GMC from really bright people writing briefings, analysing government policy—the smaller colleges don't have that, so having a large college overarching would give the economies of scale, which could well be the answer, but you and I both know, improbable, isn't it?

Professor Sydney Lowry:
When Sir John Took spoke to us a year or so ago, he expressed concern about role substitutes. Is the GMC concerned about role substitutes?

Sir Peter Rubin:
Do you mean by that, nurse practitioners, physician assistants and so on?

Professor Sydney Lowry:
Well, physician assistants and podiatric surgeons.

Sir Peter Rubin:
I am not concerned about other health profes-

sions doing what they may well do better than doctors do. What I'm concerned about is not confusing a nurse endoscopist with a gastroenterologist, because nurse endoscopists will be very good at working to protocol.

Gastroenterologists are the people that would be working off protocol and dealing with the complications. 20 years ago, 30 years ago, oh dear, oh dear, 30 years ago, I started in Glasgow, a nurse practitioner-run hypertension clinic, which worked really well, because there are some things nurses do much better than doctors do, and taking blood pressure accurately and recording it is one of them, and so the nurse practitioner ran the clinic really well, but we were always there to see patients who were off critical. That, I think, is what doctors are for, so unlike John, and I know John Took very well; unlike John, I'm not concerned, provided that there's absolute clarity about the difference in the roles, and where the buck stops, and it stops with the doctor.

Professor Cupples:

Bob:

Professor Robert Stout:

Thank you for that excellent lecture. I have a question, but first the Beveridge report, which I first came across a few years ago, just to add to what you were saying. As I'm sure you know, the Beveridge report was the best-selling government document ever published in this country. The second most-popular was the Denning report on the Profumo affair! Contrary to what many people think, Beveridge did not actually use the phrase, "from the cradle to the grave."

Sir Peter Rubin:

Indeed.

Professor Robert Stout:

It was used in the Daily Express, I think, of its day, and then Churchill, who made a speech on the radio about it, about six months later, he didn't much like Beveridge, but he knew a popular policy when he saw one, used it again, and that's why it became associated with Beveridge.

The question I want to ask you about is, you described very well the role of the doctor, and yet there seems to be a huge lack of public understanding of this, a lack of understanding in the media, particularly with respect to what you said about risk. How can we try and get that corrected?

Sir Peter Rubin:

I think we all have a huge role to play here, we the regulators, the medical royal colleges. We all have a huge role to play here, because the public doesn't understand risk in general, and we have a huge role to play in explaining that medicine is a risky business, but there can be big benefits from taking risks, but there can be bad consequences from taking risks, and it's not going to be a simple overnight thing, but I think all of us have to be giving the same message, and explaining it in terms that the whole diversity of the population will understand, and that's a huge challenge. All of us have been in the position, I'm sure, of sat there, explaining something to someone, thinking they've understood it, and then it becomes obvious that they haven't got a clue what we were talking about, despite the fact we think we've done it … so I agree, Bob. I think it's a huge issue, and I don't have a simple answer to it, other than we've got to take it really seriously.

Professor Cupples:

Two more questions, first, Colin and then Jack.

Dr Colin Mathews:

Thanks very much. Like everybody, I thought it was brilliant. The question I wanted to ask is just, you made a comment at the end that the doctors, the current day doctors, the future doctors, tend to be very well-educated, but sometimes don't value their role as a doctor, and you were saying that the GMC were going to maybe take that on as part of your role. How do you plan to inspire this generation of young doctors, and actually get them to value the fact that they are qualified as a doctor, and not to burn out, as some people seem to do now, because they haven't really understood the nature or the value of the job that they're getting into?

Sir Peter Rubin:

I don't want to pretend that I've got an easy answer to this, because I haven't. What I do know is that we've gone the competency route, partly because it's easy to do so, and we are measuring things we can measure, and also I must emphasise, I'm as keen as anybody in ensuring that doctors are competent in whatever technical area, but my view, and I'll be pushing this very, very strongly within the GMC as we consult, as we will do on our new approaches method, just because something's difficult to teach or to measure, doesn't mean we shouldn't do it, and I would want to see, in every curriculum, the overarching issue of, this is what a doctor is.

That comes above everything else, it comes above whether an orthopaedic surgeon can replace a hip or not. It is the doctor, to be able to put in a coronary artery stent is one thing; knowing whether you should do it or not is quite another matter, and that goes to the heart of the difference, doesn't it? I'd want that to be the ability to take risks, the ability to know when not to take risks, the dealing with uncertainty, all that, I just want to see it explicitly there at the top level, the most important thing of, was the purpose of this educational programme this person has actually embarked on, that is it. It's not going to be easy though, and the reason I'm making such a big noise about it is, I think we're in danger of losing it, unless we grab it right now.

Professor Cupples:

Jack?

Dr Jack McCluggage:

I think Sir Peter, that was a very interesting question, that last one, and I'm sure we could go on all night about it, but 1997, and the beginning of revalidation, seems a lifetime away now.

Sir Peter Rubin:

To us too, yeah.

Dr Jack McCluggage:

Can you update us about the timeframe, when does it actually go to the heart of doctors' lives? I know that they are building towards it, but what is the actual timeframe?

Sir Peter Rubin:

Autumn 2012. All four governments have signed up, for autumn 2012, and we could start revalidation in a number of specialities, a number of locations around the UK, tomorrow, quite frankly, the pilot sites, a number of areas here in Northern Ireland, for example. We could start tomorrow, so the key thing for us is to get going and start. We're not going to start everywhere on day one, it's not going to be a big bang for the whole country, but we'll start, and it'll be then phased in over the next two to three years, so autumn 2012 is when it's going to start.

Professor Cupples:

Thank you very much indeed. I think we could ask you many more questions, but I think we'd better give you a chance to gather your breath.

Sir Peter Rubin:

Thanks very much, Margaret.

Professor Cupples:

Thank you again.

I've a couple of housekeeping points to make. I can't say thank you enough to Sir Peter, but I hope that maybe he will take some more informal questions over a cup of tea or coffee downstairs, and I hope you'll all stay to join in an informal discussion over that. John Craig is our secretary. He has asked me to remind you that there is a golf competition for the Ulster Medical Society on 12th May this year, and he would be very keen to speak to anyone, or if anyone speaks to him, who would be interested, or who might bring friends to join in that. John is there, I think everybody knows him, so please would you think about it and get in touch with him as soon as possible.

There are some certificates of attendance at the end that we'll be useful for your re-validation folders in due course, and I'd be very happy if everyone who's here would actually sign either the members' book, in the visitors' column, the members' column, or the fellows' column, and thank you again for coming. This is the last of our winter series for this year, and I look forward to seeing you again in the autumn, if not, the golf competition. Thank you.