

Aspiring to excellence

Independent inquiry into Modernising Medical Careers (MMC) Interim Report.

Led by Professor Sir John Tooke

This report is of fundamental importance to the National Health Service. The scandal of MTAS is well known. It was no surprise that a hastily put together questionnaire, that lacked even face validity, failed. It was designed to select the brightest and best, following a first postgraduate foundation year for young doctors, to move on to higher education and training. The full spectrum of specialties, including General Practice, would follow for successful candidates. Professor Tooke ('Tooke' is used here as a shorthand for the whole of Professor Tooke's panel) starts his report with a quote from Sir William Osler outlining what constitutes excellence in medicine. Few would disagree with the wisdom of these words. Here they reflect the determination by the panel to preserve the high standards that we have all experienced if not from all, at least from most of our teachers. The corresponding quality is shown in the impressive attention to detail, care in the methodology and the breadth of this report. The methods used were analysis of minutes of the planning meetings, literature review, an e-consultation, oral and written evidence and taking evidence from specialist sub groups. The views of trainees currently in the scheme were accessed by written requests, in group discussions and by a set of written questions.

The MMC scheme was planned to be centralised and cover all those wanting to achieve excellence. Tooke outlines the steps that led to the MMC scheme from *achieving a balance (1988)* and *unfinished business (2002)*.

The calculation of manpower needs in each and every specialty must be inherently difficult. This reviewer claims no expertise and would regard a crystal ball as a useful piece of technology. Tooke reports that the

policy objective of medical training is unclear and far from agreed by the stakeholders concerned over the whole of medicine let alone the individual specialties. It was possible to identify three groups:

- The Royal Colleges and BMA regarded the rapid rise in the number of medical graduates as a problem. They wanted run-through training programmes designed to deliver more consultants jobs. Tooke found run through training unacceptably rigid.
- Trusts, service and DH workforce policy were concerned about getting the job done in a service weighed down by numerous expenses (including PFI payments). They wanted a service driven by a large and low cost pool of doctors at SHO or 'trust doctor' level. Tooke quickly judged this unacceptable. There is a persistent problem at present of doctors stuck in the SHO grade – a useful but undervalued and even forgotten group of colleagues stuck with few opportunities of advancement - 'a lost tribe'.
- Chief Medical Officer/ Postgraduate Medical Education and Training Board (PMETB) want a training programme that delivers safe, accredited doctors to provide a high standard of service to national standards of care.

The background and context of post-graduate training is described by Tooke under the interlinked headings of the service environment, medical workforce planning, the academic environment and regulation.

Emboldened by the NHS Plan 2000 and the Wanless reports, the expansion in the total spending on the

NHS has increased from £63bn in 2001-2 to £107bn in 2006-7. An architect, involved in PFI work, commented to this reviewer a year or two ago that the money 'swilling around' in the health budget which, as employees we never see, was an invitation to waste and corruption – or simple confusion.

The report moves on to discuss the background and context of higher medical education and training. NHS care in the four nations within the UK has developed in different ways. England developed according to a business model. This had started in the Thatcher era but, after a short pause, New Labour pursued it with new and relentless determination. Strategic activity moved from Regional Health Authorities to 25 Strategic Health Authorities then within 3 years to 10 Strategic Health Authorities over less than a decade. Funding of individual clinical activity moved from block grants towards 'payment by results' schemes, where every medical activity was given a tariff and this was invoiced.

The separation of purchaser and provider, the establishment of tight budgets and financial targets continued to divert energy and money from clinical care.

In 2004 a new organisational entity, the Foundation Trust, suddenly appeared. Some of the best-equipped and staffed hospitals in the land rushed to the head of the queue to join. The principle of the Foundation Trust is that they are outside the management control of the Department of Health. They raise their own funding from the equally problematic payment by results scheme and in doing so, they lock this method of finance more tightly into the total system. Governance is by a management board and a committee drawn from the surrounding local population. They are answerable to the regulator and Parliament.

Tooke makes no or little comment on training in the other three nations in the United Kingdom. The European Working Time Directive presents further problems. Tooke believes that medicine is best learned by guided experience, at the bedside or in the clinic supported by teachers, critical reading and discussion but first and foremost by clinical practice. Fitting this into a limited number of hours per week is very difficult.

The current scheme consists of two years foundation

years where there has been one in the past. As a result of the evidence they gathered, Tooke advised the reinstatement of the one foundation year, the trainees experienced the second year as repetitive and *déjà vu*. Professor Tooke's first and last statement is "this must never happen to British Medicine again." I hope this is true but was also encouraged, that when this poorly thought through and hurriedly introduced scheme was introduced without prior piloting, there was a healthy reaction of outrage.

Several thoughts went through my mind as I read and tried to absorb the implications of this interim report. They were mostly to do with the addition of a further layer of reorganisation on top of a scheme that has such problems already. The obsessive need to introduce a culture of privatisation is implicit in the commercialisation in England. One health economist commented that the ward closures and threatened trust bankruptcies were 'creative chaos' Perhaps he means that the system is designed to confuse and stress the less powerful stakeholders so that they will conform – but conform to what?

Tooke lists eight themes for corrective action. The present article is just a review of the Report but one example will clarify the process.

Item 2 is "Consensus on the role of doctors needs to be reached by the end of 2008 and the service component of trainees better acknowledged"

Behind this statement and fully discussed in the body of the report is the whole question of financing of the trainees. The traditional arrangement was that doctors worked ridiculously long hours and returned a highly valued service, mostly on a barter basis. Now the value of hands on experience is less easily acknowledged, hours are strictly controlled and book and tutorial leaning has taken its place. There is also disapproval of senior to junior doctor relations as 'patronage' and part of building an exclusive "doctors club".

The first private medical school was announced in the BMJ last week. In that scheme, clinical experience will be bought in from NHS hospitals. So has it come to this, that clinical experience will be bought from a privatised NHS?

RORY NICOL
Aka (For the passport) Ruaraidh Neacail
Guest Editor

The Annual General Meeting of the Association was held on 6th October at Friends Meeting House, London Reports from the Chair and Hon Treasurer appear below. Names and contact details for the new Executive Committee are published elsewhere in this Newsletter. Minutes of the AGM have been sent to all those who registered for the meeting and to the EC members. They are available on request to any other member, by email or post.

CHAIRS' REPORT

There have been many active topics this year including MTAS, MMC, the Darzi report, privatisation, the market, private finance and the progress of Keep Our NHS Public- our largest area of activity. The government still seems determined to put at risk the viability of the NHS as an overarching organisation.

We owe thanks to the President Peter Fisher who carries out many functions not normally undertaken by a president! Jacky Davis, our co-chair, has been very active in BMA Council and KONP. She visited Vancouver by invitation to discuss Canadian and UK health service problems (Newsletter June 2007).

The Executive committee has met 4 times with an average attendance of 9. Many members just cannot take the time to attend. We are sad to announce the resignation of Rory Nicol, honorary secretary, for personal reasons. He has been extremely positive, effective and thorough. We need a new secretary and other new members particularly from West Midlands Region. Committee member Andrew Porter is ill and may I on your behalf send him and Brenda a letter of

encouragement and hope? Guy Routh and John Ward have resigned from the committee. The former because he spends much time in Greece and cannot attend meetings. Thanks to them both for their major contributions to the Association.

The meetings have been booked at UNISON.. There has recently been a message from UNISON that we might not be able reliably to book meetings there in future. We await clarification from UNISON on this.

Our membership has grown to nearly 700 thanks to the President's invitations and perhaps the major errors of the government which have so damaged the NHS. The matter of attracting more members eg General Practitioners has been raised before.

Is it worth writing to a group of GP members of KONP to assess the chances of increasing our membership?

The Newsletter has grown with lively and varied writing. Congratulations to the contributors.

CHRIS BURNS-COX
Co-Chair

HONORARY TREASURER'S REPORT

This is the first year for some time in which the "Honorary Treasurer's Team" have not been preoccupied with the process of raising the Annual Subscription. We do, however, still continue to have a significant number of banking errors emanating from the changing of Bankers Orders.

The President, in addition, to all his other contributions to the Association continues to keep the finances flowing during my long sojourns in France. The Auditor Mr. Bob McFadyen has, once more, kept our accounts in impeccable order as is seen in his accompanying report again produced in a very short space of time.

The "increase" in the Associations financial assets is illusory. The apparent £2,800.00 augmentation is offset by our recent £1,500.00 donation and £2,000.00 commitment to financing appeal advertisements in selected local newspapers, both for the Keep Our NHS Public campaign position. Thus, as an Association we have contributed £11,000.00 to KONP this year in addition to the £13,500.00+ last year. Unfortunately support to KONP from other sources has been poor which has left it in a somewhat precarious financial situation. The AGM will need to decide on the future level of support from the NHSCA.

The following points will help clarify some of the issues arising from the accompanying audited accounts:

- 1] At nearly £630.00 the net cost of the AGM (more than double the previous year) is more than I feel appropriate. I believe that members do not pay their subscriptions to support the minority who attend the Annual Conference. This view is not supported by a majority on the committee. I would be interested to hear the views of those attending the AGM as to the appropriate amount of subsidy from the Association's coffers.
- 2] The cost of Committee meetings will not remain zero in ensuing years. We no longer have the free use of venue as we were able to enjoy under the previous Chairperson. Indeed we are not able to use the UNISON facilities we had used for many years so there will be significantly greater expense (approximately £500.00) in this area in future. Similarly the tiny amount of travel expenses is an aberration due to the nature of those attending the meetings all being local travelers. I would anticipate a figure of about £1,000.00 in future.
- 3] All other expenditure changes are within the expected "normal variation" range!
- 4] Do we continue our support for the NHS Fed and Health Matters at the same level?

There are no other significant changes between comparable years.

JONATHAN DARE
Honorary Treasurer, NHSCA

Conference –

“The Future Configuration of the NHS”

Where the speakers were able to supply a script this is reproduced in full, otherwise there is a report by one of the Committee

Hospital Reconfiguration and the Misuse of Evidence

Introduction

Reconfiguration, like a growing number of policy areas, draws to our attention a particular feature of the policy process in the early twenty first century. Namely, that controversial policy decisions are increasingly justified on technical grounds and, on other side of the coin, that matters of technical detail have come to take on a huge political significance. And what this technicalisation of politics or this politicisation of the technical means is that: first, the ability of all of us to some extent - but especially the wider public - to engage meaningfully in political dialogue, lobbying, campaigning and protest is severely challenged by the wall of technical argument that one encounters; but also that what we say and write as professionals and academics – in other words, what we as ‘experts’ say can be taken up and infused with political potency to be used by one side or the other in the battle over the controversy at stake.

So it is incumbent upon us all, professionals, health service managers and academics, to pay close attention to what we call ‘the evidence’.

There are a couple of aspects of the reconfiguration debate on which I am going to focus which illustrate the problem of the way in which evidence is constructed and misused. I will make reference to two major service reviewsⁱ in Greater Manchester which eventually were referred to the Independent Reconfiguration Panel (which endorsed the proposals for change in August 2007)ⁱⁱ. I was asked by Rochdale Metropolitan Borough Council to write a reportⁱⁱⁱ to strengthen their case against the proposed reconfiguration of services for Rochdale Infirmary.

Reconfiguration and the volumes/outcomes argument

There are several passages in the Manchester documentation, including public consultation documentation, documentation relating to clinical views underpinning the formulation of preferred options and citizen council deliberation which betray two assumptions. These are first, that outcomes in larger units are superior to outcomes in smaller units; and second, that the outcomes of physicians or surgeons with higher volumes of cases are superior to those of doctors who see fewer cases.

The evidence for the claim that higher volumes of cases will lead to better patient outcomes is limited and problematic. Two key systematic reviews (Fergusson et al^{iv} and Halm et al^v) analysed research up until 1996 and 2000 respectively. They found there is no general relationship between volumes and quality; there is evidence of an association for some procedures and conditions but the magnitude of the relationship varies considerably and the policy significance cannot easily be inferred. Since 2000, there have been many further studies but these have not been systematically reviewed. Many purport to demonstrate a volumes/outcomes link in some procedures. There are, however, a number of persistent problems with this body of literature of which those who would concentrate our services into fewer bigger units should take note.

Most research is conducted in relation to surgical procedures rather than medical interventions; on adults rather than children and young people (although there is a reasonable amount on babies); on hospital volume rather than doctor volume; in US rather than UK settings.

Where a volumes/outcomes relationship is demonstrated to exist, this tends to be true only on the average and surgeons and hospitals with the same volumes may have very different outcomes.

Despite some improvements in more recent studies, many are marred by methodological problems: inadequate operationalisation of adverse outcomes; use of routine administrative data raising concerns about completeness, the impact of the billing context, insufficient information regarding full severity of condition and extent of co-morbidity^{vi}; deployment of inappropriate statistical methods^{vii} which dichotomise what should be treated as a continuous variable with no agreement among researchers as to what should count as ‘low’ and ‘high’ volume.

The question of causation is unresolved; any demonstrated association between volumes and outcomes does not tell us what the underlying causal mechanisms are. Volume is a structural feature; it does not ‘cause’ a lower mortality rate.

Causation in health care does not take the form of a simple chain of events but instead is complex and contingent. We should be on our guard in relation to any suggestion implicit or explicit that concentration into larger units will itself produce better outcomes. It short-circuits proper investigation and deliberation. Any association indicated in the statistical analysis should be the *starting* point not the end point when it comes to inferring policy significance. The quantitative studies need to be complemented by qualitative research into factors such as staffing levels and skill mix, models and processes of care, protocols and the consistency of their implementation, the quality of nursing care and so forth. It may be that the best policy response is not to concentrate but to identify care practices which are of proven efficacy and to transfer these to units with poorer outcomes^{ix}.

Reconfiguration and staffing considerations

The second question I want to look at in the reconfiguration process relates to staffing. There are several different aspects of staffing which may be invoked in any reconfiguration, typically to assert that fewer sites are required to respond to an alleged 'shortage' of staff. In one of the Manchester service reviews, it was claimed that an extra 213 doctors would be required to achieve EWTD compliance within the current configuration, doctors who were considered neither available nor affordable.

'Safety' takes on particular significance here since 'standards', sometimes professionally determined, may indicate minimum or desirable staffing levels. The IRP report itemises several published 'standards for good practice in maternity services', the majority of which relate to staffing requirements, including the number of hours of consultant presence. The IRP finds that there is a 'broad consensus of clinical opinion' in Greater Manchester that it is not possible to meet these standards within the current configuration of services and that a reduction in the number of consultant-led maternity units is inevitable. The IRP also finds that in relation to the forecast number of births 'a total of no more than eight consultant-led maternity units across the review area would be *appropriate*... which would ensure that each unit was of an *appropriate* size of between 2,700 and 6,600 deliveries per year' (para 5.2.6, emphasis added). However, I am not aware of any empirical evidence to back an assertion that a maternity unit size of between 2,700 and 6,600 deliveries per year is *inherently* appropriate, optimal or anything else in relation to *outcomes*. 'Appropriate' seems to be a function of resource constraints - staffing and/or financial.

Here, the 'disastrous failure of workforce planning'

declared by the Health Select Committee in conclusion to its inquiry^x seems likely to have played a critical part in some reconfigurations. We should also question why funding is not available to meet the costs of long-standing local services and whether this is related to the typically high transaction and overhead costs associated with market systems in health. I have seen no comprehensive analysis of these costs which should be considered alongside the financial flows 'leaking' out of the NHS as a result of contracts with private companies which are expensive and of dubious value for money. Third, these service reductions raise a concern that staffing considerations – EWTD, MMC, recruitment and so forth - are shaping our health services rather than the other way round.

I have not reviewed the evidence base underpinning the standards referred to above but this may repay further scrutiny. They include recommended (and rising) hours of consultant presence. In 2005 the RCOG investigated *The Future Role of the Consultant*^{xi}; it asserted that 'there is growing evidence that increasing the input from consultants on delivery suites will improve outcomes (Appendix 2)' (p17). However, the evidence base offered for the outcome claims made is weak. For instance, the 'evidence' for a reduction in the caesarean rate is a 'personal communication' from a JJ Walker and no data are presented. A figure (p41) used to illustrate the claim that there is an association between consultant presence and the proportion of babies who die or are severely disabled omits sample details and is poorly labelled, incomplete and ambiguous. Indeed, this figure represents a textbook example of how not to present data, to put it generously and the NPSA raw data cannot be easily obtained for independent scrutiny because the source is another 'personal communication'. The article cited in support of the claim that an increased consultant presence will reduce complication rates from vaginal operative deliveries does not explicitly address this association although it identifies moves to improve morbidity through training and points to the complexity of assessing maternity outcomes. Overall, the figures supplied in the appendix do *not* point to the need for more consultants (as opposed to more midwives, for instance) in any straightforward way.

Despite the weaknesses in the evidence base offered, the Academy of Medical Royal Colleges, in a review of acute health services published in September 2007^{xii} (and widely perceived as a significant contribution to the reconfiguration debate), under a discussion of 'proposals to improve the quality of care', cites *The Future Role* to reiterate the assertion that 'the evidence indicates that senior involvement leads to improved safety, less intervention and better outcomes' (p24).

Conclusion

Both the volumes/outcomes debate and the presentation of the case for an enhanced consultant presence in obstetrics demonstrate that there is a problem with the way in which evidence is being constructed and reported. Despite the flaws in this evidence, it is being used as part of the case for reconfiguration. Some engaged in the reconfiguration process are making claims which are inaccurate and potentially misleading.

And, as they say, 'knowledge is power'. This misuse of evidence is politically significant and has political consequences. The impression is being created that there is a strong evidence base when I think we have quite a weak evidence base for what we are proposing to put in the place of our current arrangements. There's no real analysis of the dysfunctional effects of pulling some services out of DGHs – for instance, as to whether the remaining services will be compromised by reduced resources (exacerbated by PbR), weakened overall skill and competence and poorer staff morale. Further, simply tracking what exists in the community and how that is augmented by a transfer of services into the community is extremely difficult. It is easier to disguise the reduction in service levels and quality in the community because everything is more fragmented and care sometimes occurs in private spaces where there is no public scrutiny. A consequence of this is that services can be harder to defend. Hospitals are complex entities or systems within a wider complex system and health outcomes emerge from that complexity – and not from a single factor such as the volume of cases or the number of consultants on a labour ward.

Technical arguments and claims to evidence are being used in the exercise of power. These arguments and claims confer an appearance of legitimacy on the proposals for reconfiguration. But we should be aware that these proposals - coming on top of the restructuring of the NHS as an open competitive market, the destabilising effects of PbR, the growing role of private companies and the psychological or cultural (as much as practical) consequences of fostering a more individualistic and consumerist attitude through patient choice – this reconfiguration in combination with these other major developments is part of the process of transforming the NHS into an organisation which is quite different from what it used to be. For some people, that transformation is a wholly desirable thing; for me it threatens the foundation principles on which the institution was created: universalism, economy, equity and solidarity.

In the face of public hostility and in response to the demands of democratic accountability, the government

and its servants put technical arguments to persuasive ends. This serves to legitimate the transformation of the service into something new. Some stand to benefit and some stand to lose from this transformation of the service because resources and power are being redistributed. We have to acknowledge that our evidence is not neutral in its impact but is politically consequential and we have to acknowledge that we probably need to adopt a more sceptical stance towards the 'evidence' we encounter than we think.

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ⁱ Review entitled *Making it Better, Making it Real*, undertaken by Joint Committee of PCTS; papers can be found on the Manchester SHA website; Review entitled *Healthy Futures*, undertaken by Joint Committee of PCTS; papers can be found on the MSHA website

ⁱⁱ The reports can be found on the Independent Reconfiguration Panel website.

ⁱⁱⁱ S Ruane (2007) *Report Commissioned by Rochdale Borough Council Re: The Healthy Futures and Making it Better Proposals for Health Services in Rochdale*, Leicester: Health Policy Research Unit, De Montfort University. Found at:

<http://www.rochdale.gov.uk/pdf/2007-06-14-hospital--changes-report-v1.pdf>

^{iv} Fergusson B., Posnett, J. and Sheldon T. (1997) *Concentration and Choice in the Provision of Hospital Services*, Report 8 of the NHS Centre for Reviews and Dissemination, University of York

^v Halm E., Lee C., and Chassin M. (2002) 'Is volume related to outcome in health care? A systematic review and methodological critique of the literature', *Annals of Internal Medicine*, 137: 511-520

^{vi} L Iezzoni (1997) Assessing quality using administrative data, *Annals of Internal Medicine*, 127: 666-674

^{vii} In addition to Iezzoni, see D Urbach and C Bell (2002) The effect of patient selection on comorbidity-adjusted operative mortality risk: implications for outcome studies of surgical procedures, *Journal of Clinical Epidemiology*, 55:381-385; and L Durairaj, J Torner, E Chrischilles, M Vaughan Sarrazin, J Yankey and G Rosenthal (2005) Hospital volume-outcome relationships among medical admissions to ICUs, *Chest*, 128: 1682-1689

^{viii} I am indebted to Prof D Byrne and Dr K Yang for their advice on this.

^{ix} See L Durairaj et al (2005) *ibid* for an excellent discussion of some of the issues involved in drawing out policy significance

^x Health Select Committee (2007) *Inquiry into Workforce Planning* Vol I, p3

^{xi} RCOG (2005) *The Future Role of the Consultant*, A Working Party Report. London: RCOG

^{xii} Academy of Royal Medical College (2007) *Acute Health Care Services: Report of a Working Party*, London: AMRC

CHANGES IN PRIMARY CARE

DR CHRIS JOHNSTONE

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In her introduction to this paper, the chair, Dr Jacky Davis, suggested that doctors in primary care had been slow to see the dangers of privatisation to themselves. Dr Johnstone thought that we had all been slow to grasp the fact that devolution has created four National Health services. At least in Paisley, this could be explained by the fact that political devolution had left Old Labour in charge.

MARKET FORCES

New Labour avoided public consultation in their introduction of Private Treatment Centres and accelerated the extension of market forces in the NHS. In England the market is being tested all over. Using a large Parliamentary majority, much of which was of Scottish and Welsh Labour MPs, the Blair government drove forward on Foundation hospitals, ISTCs, APMS, PPI, PPS, and CfH. Market forces are only one part of many changes swirling around the general medical practitioner. There is an ageing population, a swelling general population, rapid advances in medical and in pharmaceutical technology and confusion in the training and recruitment of doctors. Of all these, the introduction of commercial medicine is the most significant.

THE NEW MEDICINE

Professor David Kerr, author of the eponymous report, described the difference in attitude between the NHS in England and in the Gallic nations : England went hell for leather for Contestability and Competition, whereas the others went for Collaboration and Collectivism. Initially, the Scottish Labour administration showed a desire to cooperate with New Labour's schemes, but the massive overspend on a useless computer project, dwarfing by comparison the large increases in GPs' earnings, has made

them less enthusiastic. Furthermore, it seems that few politicians were aware of the special status of GPs as independent contractors within the NHS and that they kept their own list of patients, even when part of a large group practice in a health centre.

NEGATIVE ASPECTS OF THE NEW CONTRACT :-

1. A LOSS OF MONOPOLY TO TREAT PATIENTS

The new contract provides that general medical services can now be provided by private contractors who may employ staff NOT registered with the General Medical Council.

2. NO OWNERSHIP OF PATIENT LIST

In the event of a practice breakup , the local Primary Care Trust reallocates the list of patients, rather than leaving patients with the named doctors. GPs who break up a practice now are in danger of finding themselves in great difficulty, without premises, without patients and without an income. There is compelling pressure to ram doctors together in ever larger groups

3. GRADUAL REPLACEMENT OF DOCTORS WITH CHEAPER ALTERNATIVES.

4-5% of English GP practices are now run by commercial companies who , in an unpiloted scheme, employ salaried doctors, backed up by ample nursing assistants, who take a detailed and ongoing interest in small groups of patients, such as diabetics. Thus, doctors lose their special status, while much work is done at a lower level of expertise and salary.

4. MANIPULATION OF PRIVATE SECTOR INTO PRIMARY CARE

Salaried GPs on limited term commercial contracts are not allowed to bid for their own practice when

their Primary Care Trust puts it up for competitive bids. Preference is to be given to the bidder with the largest capital resources. This also deters other doctors looking to establish themselves in a small practice.

5. NEW IT SYSTEMS DRIVE A WEDGE BETWEEN GP & CONSULTANT

Despite politicians' claims to have increased choice for patients, the actual result of the new systems is to impose a filter barrier between GP and consultant. Clerks in the administrative office are free to change 'urgent' to 'non-urgent', and to decide which consultant will receive the referral and at which hospital. Choice is non-existent in most parts of the country. This system can only be short-circuited by a private referral to consulting rooms .Similarly, when the consultant wishes to reply to a GP referral, such is the degree of mobility in general practice, that many letters are virtually anonymous.

CONCLUSION.

There is a fundamental dishonesty in the NHS that better health results from increased spending on healthcare. It is generally understood and agreed that resources are finite and that some sort of rationing must apply in the NHS. Given that, it is impossible to countenance the diversion of very considerable sums of NHS money to the commercial sector for services of doubtful value. At a time when healthcare needs are increasing , as the population ages and expands; when medical unemployment leaves hundreds of freshly trained doctors searching for employment; at such a time it is profoundly to be hoped that the government will not stand waiting for some help from market forces.

JOHN DUNCAN

Has Modernising Medical Careers lost its way?

Modernising Medical Careers (MMC) began as an attempt to address longstanding problems with the senior house officer grade. The consultation paper *Unfinished Business* written by Chief Medical Officer Liam Donaldson proposed 5 key principles upon which reform should be based. These were that there would be a programme of training which would be broadly based, time limited and individually tailored to the trainee's needs. There would be flexibility to allow individuals to move in and out of training and between training schemes. Specialist and GP trainees would enter these broadly based specialist training schemes for 2-3 years and then to move on to more highly specialised training. However Donaldson went beyond his original brief by suggesting that consideration should be given to run-through training. Responses to *Unfinished Business* were generally favourable, although there was some criticism of the proposals for run-through training. The BMA pointed out that issues not originally considered by the Working Party had been promulgated and the president of the Royal College of Physicians that the final product was a far cry from what the Royal Colleges had originally signed up to.

The health ministers ignored these responses so that the training scheme that was implemented in August 2007 was in fact remarkably similar to the tentative proposals for run-through training in *Unfinished Business*

There are 5 major stakeholders in these reforms: junior doctors, medical workforce planners, NHS employers, Government, and patients.

The current plans are disappointing for doctors, who need a robust, modern and flexible training system which satisfies the 5 key principles for reform originally outlined.. Specialist training will be programme-based and time-limited, but it will not be as broadly based as originally envisaged, nor will it be easy to move between programmes. The idea of individually tailored programmes also seems to have been forgotten, career advice is currently

lacking, and the provision for flexible training is uncertain. MMC therefore fails to meet most of the principles on which it was supposed to be based.

For workforce planners, the lead time for planning future consultant numbers will increase from the 3-4 years that would have been the case under *Unfinished Business*, to 5-7 years if MMC continues to be implemented in its current form. NHS employers will see a reduction in the number of Senior House Officers, their most flexible medical staff, and a reduction in their time spent providing a service in favour of training. A workforce made up of doctors forced into specialties they did not really want is not a happy prospect either.

It's better news for the government, which will see its 'increasing need for hospital services to be delivered by fully trained doctors' met by the shorter training, and thus longer time spent as a consultant.

Patients, though, may suffer as a result of being treated by senior doctors who have a very narrow range of experience and expertise such that they are unable to manage unusual emergencies or easily adapt to medical advances.

It is difficult therefore not to conclude that MMC has lost its way and will not fulfil its original aims.

That said, Sir John Tooke's review of MMC may well lead to significant changes in the way things move forward. Some of the submissions to his review suggest a reversion to the key principles outlined by Donaldson, while the extent to which any recommended changes are put into practice will depend almost entirely on politicians.

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ISTCs, CATS and ICATS

Colin Leys

Emeritus professor, Queen's University, Canada

The starting-point for understanding the Independent Sector Treatment Centre (ISTC) programme is that it is a key step in the Department of Health's (DH) strategy of converting health care in England from an integrated public service into a mixed public and private healthcare market. The idea is that only a competitive market will keep costs down. Such evidence as we have suggests that markets make health care more costly, not less, as well as inequitable. But this is the strategy, and the ISTC programme is at the heart of it.

The official rationale for ISTCs consists of a series of claims that are not supported by the evidence. Its real aims lie elsewhere: *First*, to normalize the presence of private providers in NHS secondary care, for both patients and NHS staff. *Second*, to force the UK private healthcare sector to restructure, so as to start competing with NHS trusts at the NHS tariff. *Third*, to oblige a growing number of clinical staff to work for for-profit employers instead of NHS trusts, and gradually normalize a career in private sector medicine as an alternative to NHS medicine.

There were to be two waves or phases of the programme. Wave 1 ISTCs mainly do hip and knee replacements or cataract surgery. There are eight companies, operating 24 centres or (in one case) mobile operations.ⁱ

The centres are intended to be permanent providers of NHS services. Their contracts normally run for 5 years, but are renewable. They have now been allowed to call themselves NHS Treatment Centres, making them indistinguishable from the existing NHS treatment centres, even though they are privately-owned and profit-making, and they have been admitted to full membership of the NHS Confederation.

The official aims of the ISTC programme.

The official aims of the ISTC programme, given by the DH to the House of Commons Health Select Committee last year, were: a) to increase capacity in order to cut waiting times for elective care; b) to increase choice; c) to introduce best practice and innovation; d) to stimulate reform and efficiency in the NHS; and e) to 'assist reconfiguration; for example, existing hospitals might be closed and some of the facilities replaced by an ISTC'.ⁱⁱ

a) *Increasing capacity*

The most important of these aims, the DH told the Health Select Committee in 2006, was increasing capacity. But if this was the case, the programme should have been scrapped already, because on this count it has failed completely. The actual number of procedures performed has fallen dramatically short of the 170,000 a year officially expected, and of what was contracted for. The first ISTC opened in October 2003, and although start dates in the contracts were staggered, by 2005 the majority were up and running. Down to April 2007, however, the total number of elective procedures carried out was just 128,000 (Table 1, column 4). The total for 2006-2007 – the fourth year of Wave 1 – was either 59,960 or 107,000, depending on which of the two figures in Table 1 (columns 4 and 5, both provided by the DH) one chooses).

Table 1

Procedures said to have been carried out by Wave 1 ISTCs down to April 2007: cumulative totals

	1	2	3	4	5
	To Dec 2005*	To Apr 2006**	To Jan 2007#	To April 2007***	To April 2007##
Electives	44,000	59,960	107,000	128,000	167,850
Diagnostics	9,000	25,151	60,000	73,000	307,435
Total	53,000	85,111	67,000	201,000	474,870
Primary Care		11,679		140,485	

Sources

* Department of Health, evidence to the Health Committee, *Independent Sector Treatment Centres*, Fourth Report of Session 2005-06, Vol II Ev. 1

** Answer to Parliamentary Question by Andrew Lansley MP, Commons Daily Hansard, Written Answers, 13 July 2006: Column 2062W.

Department of Health Response to Freedom of Information request, DE00000189579, 27 March 2007.

Data supplied by the DH to the Healthcare Commission and published in its report, *Independent Sector Treatment Centres: Review of the quality of Care*, July 2007, p. 6.

*** Department of Health response to FOI request, DE00000241293, 22 October 2007.

The data in Table 1 are problematic in several ways. No routine performance data for ISTCs have been published. The data in Table 2 are those provided in

response to parliamentary questions or FOI requests, or supplied to the Health Select Committee or the Healthcare Commission, and ‘procedures’ appear to include both diagnostic tests and primary care, rather than the Finished Consultant Episodes which were originally mentioned to the Health Select Committee. The late inclusion of data on primary care, for example (some of which was included in the proposed case-mix of one ISTC listed in the DH’s submission to the Health Committee, but which has no obvious bearing on capacity for elective care), looks like a case of data inflation. It is also hard not to feel somewhat sceptical about the sudden jump in the number of elective procedures said to have been carried out in the most recent year, 2006-2007, even if we take the lower of the DH’s two figures for 2007 (Table 1 column 4). But even if we take the larger figure given by the DH to the Healthcare Commission (Table 1 column 5), which includes ‘elective procedures including those done under the GSUP1 and 2 contracts, and diagnostic assessments undertaken through ISTCs as well as the pathfinder programmes’,ⁱⁱⁱ it is still not a significant contribution to the NHS’s elective capacity. The DH admitted to the Health Select Committee that ISTCs had not made a significant contribution to bringing down waiting times.

They are also very costly. All ISTC contracts are treated as commercially confidential. But we do know that the contract price per procedure is well above the price paid to NHS trusts – according to the DH it is on average 11.2% above something called the NHS Equivalent Cost, which is itself above the NHS tariff.^{iv} We don’t know how much above. Not even the Health Select Committee could be told, not even in a closed session, on the grounds that to reveal this would jeopardise the government’s future procurement efforts.

But on top of this the procedures actually carried out by ISTCs – as opposed to those contracted for - are often even more expensive, because under Wave 1 contracts they are paid for regardless of whether or not they are performed (the whole ‘demand risk’ is borne by the NHS). This means that the price per procedure actually carried out can be several multiples of the contract price. One PCT in Stoke on Trent notoriously paid £2 million for 59 procedures that were actually performed, and it is not a unique case.^v

There is therefore a huge opportunity cost to the NHS – a huge amount of potential capacity foregone. The reality is that ISTCs have reduced the NHS’s overall capacity, not increased it.

b) *Increasing choice*

When PCT funds are diverted from NHS trusts to

ISTCs, leading to the closure of NHS services – as has happened in many parts of the country – choice is not increased and may be reduced. The well-known case of the threatened closure of the Nuffield Orthopaedic Hospital (an NHS hospital) in Oxford is just one among many.

In some areas, GPs have even been offered money to refer patients to ISTCs rather than a local NHS trust, because the PCT must pay for patients to be treated by the ISTC whether they go there or not.^{vi} If they go instead to an NHS hospital, the PCT is paying twice. Once again, this hardly represents increased choice.

c) *Best practice*

Instead of ISTCs demonstrating best practice to the NHS, evidence soon emerged – and much of it was given to the Health Select Committee - that the standards of many ISTCs were seriously below those of the NHS. But this question could not be definitively answered because down to March 2006 the DH did not enforce the requirement that ISTCs report clinical outcome data – let alone data that could be compared with NHS data. This is hard to reconcile with the claim that the NHS’s chief executive, David Nicholson, regards ‘measurement of outcomes as the key driver of local improvement in the health service’.^{vii} Following criticism from the Healthcare Commission, steps are supposed to be taken now to rectify this failure to monitor the care given to NHS patients by private providers.

d) *Driving reform and efficiency*

The Health Committee could not find any evidence that ISTCs were diffusing innovation into the NHS. Such evidence as the Committee received showed that NHS treatment centres practised all the more advanced techniques – which is not surprising, considering that they have to deal with a significantly higher-risk case mix.

e) *To ‘assist reconfiguration’*

This brings us to the last official claim – ‘to assist reconfiguration’. This was mentioned to the Select Committee at the tail end of their hearings in 2006, and was not pursued by the Committee, but it actually points to the real purpose of the ISTC programme. The real aim has been to use NHS funds, patients and staff to introduce a new kind of private sector provider to offer competition to the NHS. This had been announced clearly in several policy papers in 2002: for example, ‘...spare health capacity in other health systems [will be] made available ... through new surgical and diagnostic units that are *set up and run by independent operators* and staffed with overseas clinicians... [This] will be *a new sector in health provision*

in England...the NHS will be the core business of units in this sector...^{viii} A Commercial Directorate was set up inside the DH to achieve this aim. It now comprises 8 civil servants and 182 people recruited from the private sector.^{ix}

The thinking behind the policy was that the established private sector in the UK was exceptionally weak. It dealt with a limited range of conditions, it had virtually no clinical workforce of its own, and was very high-cost. And as NHS waiting times for elective treatments fell, BUPA, Nuffield, Norwich Union, AXA and the rest also faced the loss of the most important motive most people had for taking out private medical insurance.

The strategic role of ISTCs.

The idea was therefore to create a new kind of low-cost, high-turnover private healthcare industry treating only NHS patients, starting with low-risk standardised procedures and guaranteed profits, and using foreign-based companies to force the established domestic private providers to restructure and follow suit. This is the real function of the ISTC programme, and explains why it has been persisted in when it has failed to deliver on the other goals officially given for it..

It also facilitates a shift of NHS clinical staff to private sector employment. One of the reasons why Wave 1 ISTCs have underperformed has been the difficulty of recruiting clinical staff. Since ISTCs were supposed to bring additional capacity they were barred from hiring NHS staff. Even when this ‘additionality’ rule was relaxed (allowing Wave 1 ISTCs to recruit, on average, 25% of their staff from the NHS), many still could not deliver their contracted activity levels. For Phase 2, however, the additionality rule has been largely abolished. This means that as NHS staff become unemployed they can move to the private sector, and will increasingly have no alternative, at least in England.

And they are becoming unemployed. A leaked DH workforce strategy document estimates that there will be over 3,000 surplus consultants in the NHS by 2012.^x And the scale of the ISTC sector originally envisaged by the DH, and the expanded network of other private providers it was expected to bring into being, indicates that this is where the surplus NHS clinical staff were likely to end up. Wave 1 and Phase 2 ISTCs combined, plus other private providers in the new ‘Extended Choice Network’ (ECN) brought into being by restructuring among the ‘incumbent’ companies (Nuffield and BUPA in particular), were projected to do a total of 560,000 procedures a year (and many more if diagnostic procedures are included) (see Table 2).

Table 2. DH projections of FCEs to be performed annually by ISTCs and other independent sector providers for NHS patients

Wave 1 ISTCs*	Phase 2 ISTCs**	Extended choice network***	Total
170,000	250,000	150,000	570,000

* The DH projection for Wave 1 appears to include both elective and diagnostic procedures, though all were described as FCEs.

**Electives only. Phase 2 Diagnostics was expected to provide ‘approximately two million additional diagnostic procedures a year’ for NHS patients.

*** No distinction was made between electives and diagnostics in the total number of procedures the DH said were expected to be done by the ECN.

Source: DH submission to the Health Select Committee, Fourth Report 2005-2006, Vol II Ev. 1

This could only be accomplished through a substantial transfer of staff from the NHS to ISTCs and ECN providers. The chair of the CBI’s health care panel saw this clearly in October 2005, when he told a conference: ‘it is no longer about additional capacity, it’s about the transfer of services.’^{xi}

Originally 24 more ISTCs were envisaged in Phase 2. By mid-2007, however, only ten were said to be under negotiation, and the consensus among health journalists seemed to be that these figures were not going to be attained. A total of 300,000 elective procedures a year to be done by Wave 1 and Phase 2 combined was thought more likely. But this had already been judged too small a market to sustain a competitive private sector. A DH-commissioned report on ‘market sustainability’ presented to ministers in 2004 had estimated that 700,000 procedures a year would be needed to secure a viable market covering the whole of England.^{xii}

But this is where CATS and ICATs (now also called CATS – ‘Clinical Assessment, Treatment and Support Services’), seemed to come in. Some of the Phase 2 ISTCs still under negotiation were CATs. Although no information on CATS has been given on the DH website, we know from press coverage of the planned CATS in Manchester, Lancashire and Cumbria that they are or were to vet GP referrals with the aim of channelling a growing proportion away from hospital-based treatment to non-hospital based settings.^{xiii}

If this model were rolled out across England the shape of secondary care would lie in the hands of the companies

that owned and operated these centres. In mid-November 2007, however, the Secretary of State announced the abandonment of six Phase 2 projects, including the CATs planned for Lancashire and Cumbria, and for Northeast Yorkshire and North Lincolnshire, saying that they were no longer needed. The number of new ISTCs still being proceeded with had fallen to eight, and only two of them – both in Manchester – were CATS.

Some commentators have suggested that this represents a retreat from the creation of a market, but within the industry it is assumed that the £4 billion earmarked for Phase 2 will still be spent on other forms of procurement from the private sector. It is perhaps significant that the DH no longer speaks of a second Wave of ISTCs, but of ‘Phase 2’ of the programme, which seems to have taken on a rather protean character. It has, for example, recently started to include procedures performed for the NHS by the eleven private providers, with ‘up to 157 hospitals’, that have met the criteria for inclusion in the Extended Choice Network.^{xiv} It also includes a large number of primary care procedures (see Table 2), most of which are being provided to NHS patients by privately-owned ‘walk-in centres’, focussed on commuters, which the DH now describes as ‘within the ISTC programme’.^{xv}

What this suggests is that further privately-provided surgery will, in the immediate future, mostly be done by ECN hospitals rather than new ISTCs, while new providers will have other opportunities. ‘Additional capacity’ has been replaced as an official target by ‘reconfiguration’, on the lines advocated by Lord Darzi and the new, somewhat secretive, ‘National Leadership Network for Health and Social Care’ which has replaced the NHS Modernisation Board.^{xvi} SHAs are now being assessed on the basis of how far the PCTs in their area are ‘unbundling’ services and commissioning them from ‘independent’ providers, rather than NHS providers. NHS secondary care delivered in ‘polyclinics’ or other non-hospital centres offers potentially lucrative new opportunities for private companies. Ministers are said to be likely to emphasise this to investors dismayed by the scaling-back of the original Phase 2 ISTC programme.^{xvii}

Conclusion

The real significance of the ISTC programme has been to serve as an entering wedge enabling private companies to become part of what the government refers to ‘the family of NHS providers’ of secondary care.^{xviii} By being made indistinguishable from trust-owned NHS Treatment Centres, ISTCs have begun to make for-profit provision seem a ‘normal’ feature of the NHS. By forcing the ‘incumbent’ domestic providers to restructure they have also been instrumental in stimulating the formation of a

much wider range of private providers. The apparently widening range of activities that are now treated by the DH as being ‘within the ISTC programme’ point to private companies providing a growing range of secondary care services that will be ‘reconfigured’ as ‘primary care’, or something in-between.

All these developments point in one direction: a growing proportion of clinical staff in England will work for private sector providers, on non-NHS terms – i.e. on lower pay and benefits and – to judge from market experience elsewhere – with less clinical autonomy. Then, competition for patient income will gradually force NHS trusts to match the terms in ISTCs and other private providers.

* This paper is based on a forthcoming report by Stewart Player and Colin Leys

Endnotes

- ⁱ The companies were: Netcare, Capio, Mercury, Nations Healthcare, Partnership Health Group, Interhealth, Clinicenta and UK Specialist Hospitals. Mercury was later bought by Care UK, and Nations Healthcare by Centres of Clinical Excellence.
- ⁱⁱ Health Select Committee, Fourth Report of Session 2005-06, *Independent Sector Treatment Centres*, Vol I, para 26.
- ⁱⁱⁱ Freedom of Information response DE00000241293, 22 October 2007
- ^{iv} Health Select Committee Report, Vol III, Ev 147
- ^v ‘Patients don’t go so why pay?’. *Stoke Sentinel*, 18 June 2007. A contract with Care UK (formerly Mercury Health) for the provision of diagnostic services in the West Midlands has been terminated ‘because of an unacceptably low rate of use (5 percent utilisation to date), and a very low prospect of the utilisation increasing which represents poor value for money to the taxpayer’ (statement by Alan Johnson, 15 November 2007).
- ^{vi} *Doctor*, 31 October 2006
- ^{vii} *Guardian*, August 28 2007)
- ^{viii} DH, Growing Capacity: a new role for external healthcare providers in England. June 2002, emphasis added.
- ^{ix} See *Financial Times* 15 November 2007, <http://www.ft.com/cms/s/0/1073a3fc-918f-11dc-9590-0000779fd2ac.html>
- ^x ‘NHS facing glut of consultants and nurse shortage’, *Guardian* 4 January 2007.
- ^{xi} ‘CIPFA health finance conference October 6–7 – Watch out, the ISTCs are coming’, *Public Finance*, 14 October 2005
- ^{xii} A redacted version of this ‘Market Sustainability Analysis’, consisting of 12 un-numbered pages is to be found on the DH website: http://www.dh.gov.uk/en/Publicationsandstatistics/Freedomofinformationpublicationschemefeedback/FOIreleases/DH_4102647
- ^{xiii} Central Lancashire PCT had decided that 100% of GP referrals in all specialties except urology would be sent to the CATS centre for ‘paper triage’ *Hospital Doctor*, 25 January 2007. The figure for Bolton was 90%. *Bolton News*, 22 January 2007
- ^{xiv} Freedom of Information response DE00000228102, 13 August 2007.
- ^{xv} Freedom of Information response DE00000241293, 22 October 2007..
- ^{xvi} The National Leadership Network is described on the DH website as “150 people who have a major contribution to make in steering the next phase: patients and users of services, clinicians and managers, professional leaders, inspectors and regulators and leaders from partner organisations”, and in promoting ‘shared values’ (the nature of which is not mentioned). Access to the Network’s website is closed to the public.
- ^{xvii} ‘Private sector role in pioneering healthcare scheme to be slashed’ *Financial Times* 15 November 2007.
- ^{xviii} Ministerial statement by Alan Johnson, Secretary of State for Health, Department of Health 15 November 2007.

Professor COLIN LEYS
University of Edinburgh

THE PAUL NOONE MEMORIAL LECTURE

DR JULIAN TUDOR HART

Hon Research Fellow, University of Wales

NHSCA , an open and honest public movement, stands as an interesting contrast to the New Labour conspirators who move secretly, avoiding the public gaze. The conspiracy is an agreement in secret to lie to the public. There will never be a public announcement of the decision to privatise the NHS : it cannot be the subject of a referendum, nor even form part of an election manifesto.

At the heart of the deception is a determination to deskill doctors.

Using the model of the Ford Motor company, an attempt will be made to divide medical/surgical practice into a series of small, independent units, producing (as an extreme example) doctors specialising in the Left great toe, but quite ignorant of the Right great toe.

At present the motor of the NHS is the consultant, while the clutch is the GP. The new, privatised NHS is to be a fully automatic model, running faster and faster to satisfy consumer demand, produced in a robotised factory. That is perhaps an unkind way to refer to nurses or non-medical assistants, but doctors need knowledge in depth and clinical experience to spot the unusual before trouble starts.

The justification for automation in factories is that it improves quality and lowers costs. Industrial systems with their tick boxes do not produce good medical care. It is not just sentimentality to talk about the importance of personal interaction: it is an important factor in high quality care.

The measurement of outcomes is a more important exercise than the

achievement of arbitrary or restrictive targets. It is relevant to comparing the efficacy and quality of care, including health education and anticipatory care. JTH gave the example of two neighbouring Welsh mining villages, both served by conscientious medical practices, the difference being that whereas one found time to measure a series of patient outcomes, the other devoted itself to the problems of the moment. We have JTH's word that the practice (possibly his ?) that tried to anticipate problems and ran various health education programs had a death rate from coronary heart disease, pulmonary conditions and diabetes 26% lower than its neighbour for men over 60. Shared care , he firmly believes, is the way ahead, despite difficulties.

John Duncan

CARA

The Continuing Plight of Iraqi Academics

An attack on academic freedom

Our support came too late for Ali Al Saadiy, a young lecturer from Basra who sought the help of the Council for Assisting Refugee Academics (CARA) to escape the daily nightmare of Iraq.

Despite the associated danger, he was eager to be interviewed for a BBC documentary following the September 2007 withdrawal of British troops. He wanted to help raise awareness of the realities and suffering of his fellow Iraqis and of the concerted campaign of kidnap, torture and assassination being instigated against academics and medics.

Ali's last email was a delightful one liner "Je suis tout a votre service... we say

that in French Language. Regards Ali" a remarkable display of light-heartedness from one who lived in fear of his life. Two weeks later we received news of his kidnap and murder.

He is but one of over 300 academics from all fields of study who have been assassinated, feared as independent thinkers with the vision to thwart Iraq's descent into anarchy and fundamentalism. Thousands more have fled to neighbouring countries where most live in poverty and confusion, without income or hope, cast as pariahs in the region and the world beyond.

The faculty members who kept the faith following the 2003 invasion, faith

in the possibility of a positive and secure future for Iraq and who remained to help in its rebuilding, were amongst the first to be targeted and faculty members from the medical colleges have borne their share of the violence. Professor Aalim Hamed, Dean of the College of Medicine, Al Mustansyria University; Prof Emad Sarsam, Member of the Medical Arab Board of Medicine and the Iraqi Board of Medicine and well known surgeon and scholar: Dr Ihsan Ali Rabiei, Deputy Dean of the College of Medicine, Baghdad University; Professor Mohammed Falah al-Rawi, Chairman of the Iraqi Union of Physicians and President of the University of Baghdad; and Khalid al

Naid, Deputy Dean of the College of Medicine, Al Nahrain University are amongst the many killed.

It is the desire to rescue and sustain this precious capital, to ensure that each is able to develop to their full potential and continue to contribute his or her knowledge and expertise, that underpins and drives CARA's work.

Founded by William Beveridge in 1933 as the Society for the Protection of Science and Learning (SPSL) in an act of solidarity, the SPSL sought to reach out to fellow academics suffering persecution and later extermination under the rise of Nazism and Fascism across Europe. Their crime? The practice of what Hitler called "Jewish Science". They became known as 'Hitler's Gift' and, of those that the SPSL assisted in the 30s and 40s, 18 went on to become Nobel Laureates, amongst whom Ernst Chain, Hans A Krebs and Max F Perutz.

There is considerable resonance with Iraq today, different of course, but, at its heart, an assault on freedom and diversity. Iraq's higher education system has all but collapsed, with universities and colleges split along sectarian lines, the personal fiefdoms of the various self-styled forces such as the Mahdi Army, with the ministries and unions increasingly split along similar fault lines. Although Iraq's higher education institutions have not been true bastions of intellectual freedom for some time, the final vestige of pretence is gone, and they have become dysfunctional antitheses of the centres of learning they purport to be. Faculty members and students alike engage at their peril in a climate of fear and oppression.

A lifeline

As part of CARA's 'Campaign of Action', it has established an emergency hardship fund through which it has been supporting at least some of the many Iraqi academics and their dependants in need.

CARA has been working primarily through members of the CARA Scholars at Risk UK Universities Network – a network of 35 universities collaborating to defend academic and

university freedoms and provide practical support to academics at risk – to develop doctoral and post-doctoral research opportunities, providing both welcome refuge and a means of continuing to contribute to developments in their fields, whilst enhancing their own knowledge. CARA, with the support of the Lisbet Rausing Charitable Fund (Arcadia), has also established a fellowship scheme to support such placements, with host universities waiving all course and/or bench fees.

CARA is also developing a regional strategy to complement its fellowship and placement work and bring hope and some means of continued engagement to many more stranded in the region through the pilot of a 'learning hub', a virtual university in exile in Syria. In Syria alone, there are over 400 academics amongst the million plus Iraqis who find themselves all but abandoned by the international community, with only UNHCR and the ICRC providing support on the ground.

A recent Amnesty International report tells of Iraqi women being forced into prostitution to help feed their families and CARA is also seeing an increasing number of academics who, having exhausted their funds, are being forced to return to Iraq where the new academic year provides their sole means of income. They return, leaving their families behind in relative safety.

Discussion is underway with potential contributors and collaborators from amongst leaders in the development and delivery of e-learning technology and materials – amongst which the Open University, which is a member of the CARA Scholars at Risk Network. CARA is looking to draw on existing resources, such as virtual libraries, and is in contact with possible collaborators amongst Syrian-based universities, having held an initial favourable meeting with the Syrian Minister of Higher Education.

CARA has also been working closely with its sister organisation in the US, the Scholars Rescue Fund, to maximise impact and avoid duplication. Their work has focused on brokering regional

placements amongst Middle East and North African higher education institutions.

It is hard to exaggerate the importance of Iraqi academics and their knowledge and skills to the future of Iraq, a loss from which it would take generations to recover.

CARA can't hope to rescue all of those in need of rescue, nor can it compensate for the lack of political will amongst those governments who bear the greatest moral responsibility, and who have done so little themselves to alleviate the plight of Iraqis, or to assist those countries who bear the brunt of the burden.

CARA can, however, make a considerable difference to many lives and is only limited by its resources. There are good news stories, and tremendous goodwill amongst UK universities and individual faculty members who welcome the opportunity to help CARA provide a lifeline.

One such story is that of an Iraqi university lecturer who lived and went to school in the UK as a teenager, whilst her parents pursued PhDs at UK universities. She not only feared the threat of kidnap and assassination that hangs over all Iraqi faculty members, but also the discovery of her mixed Sunni/Shia marriage – another crime in the new Iraq. Her husband fled to Syria, but she continued in her university post to maintain an income to support them both. At the end of the academic year she joined him in Syria where CARA provided them with hardship funding when their savings ran out. We have now, with the help of a UK university, been able to provide her with a PhD placement with all fees waived and are awaiting her and her husband's arrival in the UK.

Beveridge's vision and work remains as relevant and crucial today as ever.

If you would like more information or are able to contribute to CARA's work, please contact Kate Robertson on 020 7021 0880 or visit www.academic-refugees.org

STAFFING MEDICINE

It is uncontroversial that UK medical training is in disarray, and that recent upheavals have caused unnecessary problems and anxieties. This is especially ironic as there were originally very worthy aims to improve the quality of postgraduate education, provide security of career progression for junior doctors, and avoid the exploitation of international medical graduates (IMGs) in serial short term service posts.

Initially the NHS spectacularly underestimated the demand for health care and doctors, and entry to British Medical Schools was severely restricted. The failure of state-controlled undergraduate medical education to match the requirements for doctors in the state-controlled NHS was a shameful missed opportunity. For decades a chronic shortage of medical staff could only be remedied by employing doctors trained abroad. This usually meant taking doctors from under-developed poorer countries who could ill afford to spare them. We were the grateful recipients of a flood of foreign doctors without which the NHS could not have functioned at all for most of its life. 26% NHS hospital doctors are IMGs. The continued expansion of what is now the European Union encouraged movement also, often from countries which could not really spare staff, like Poland. (Medical gaps there have apparently been filled by Russian and Chinese doctors!). Some countries like the Philippines have had a policy of over-producing doctors and especially nurses, in the expectation that many would seek work abroad. But largely our voluntary medical immigration has come from South Asia and Africa, with a negative effect on the health care in their home countries. Economic reasons often mean that they remain in Britain. To hear that sometimes little or none of the entire output of Nigerian medical education ever seeks jobs in its own country shows that globally things are very wrong.

- 1 -

The underlying objective of recent change was to markedly increase the output of British under-graduate

medical education to match the projected demand for doctors. A huge amount of money was put into enlarging medical schools, creating new ones, and increasing the number of career NHS posts. IMGs from outside the European Union might come under supervision for proper training purposes, but the hope would be that the service needs of the NHS would be met adequately independent of their presence. After postgraduate training IMGs would normally return to their own countries to improve medical care there. The much smaller number of refugee doctors from countries like Iraq and Afghanistan does lead to a permanent migrant group, but this would not really be a problem. European Jews before 1945, political exiles from the USSR, and Czechoslovak and Maltese doctors have all in the past come to the UK and settled very successfully here to escape trouble at home.

Why we still need to have a 5 year course for most medical students is a bit mysterious. Most other UK university courses last no more than 4 years. The most useful education is practical and clinical, and acquired after graduation. Some mature and postgraduate medical students already do a 4 year course, so the principle is not new. We should resist the Bologna 2010 initiative which would be likely to lead to a 6 year undergraduate course with an initial 3 year pre-clinical degree.

The Foundation Year 1 programme seems to involve a lot more assessment and paperwork than the old pre-registration house officer year, which may be no bad thing. Disappointingly some difficulties in the quality of the Foundation Year 2 course have arisen, but the principle of 2 year generic orderly postgraduate training with a chance of early sampling of different specialities is a sound one. It is what happens next which has caused most heartache.

In the past the process was 6-12 month SHO posts, sometimes organised in 2

year rotations, or GP vocational training schemes. Appointment was achieved by length of clinical experience, the curriculum vitae and competitive interview. To progress further in hospital medicine required higher qualification and a suitable registrar (or later specialist registrar) post which was even more competitive. This was a hurdle which defeated many, at least temporarily. Particularly IMGs could get stuck in a series of SHO service posts, often in different non-academic hospitals, and have to hawk around their elderly "part 1 MRCP" in the quest for further similar posts. Some would take up positions as long term locums, staff grades, or eventually associate specialists, but it was unlikely that they would obtain consultant posts despite specialist experience and practical expertise. Sadly the SHO dilemma has not really resolved. The careers sections of journals are now full of original new titles such as "Teaching Fellow", "Clinical Fellow", or "Trust Doctor", which are often not fully recognised for training purposes.

A major fault of the old system was uncertainty and slow career progression. The original 1948 concept had been that doctors would reach consultant status by the age of 30-32 years after 7 years' postgraduate training, but in reality the shortage of posts meant that 35-40 was a more usual age for first consultant appointments.

The recent expansion in the numbers of consultant posts together with restructured training programme was supposed to lead to a better outcome, but it is not the case yet! The new Medical Training Appointment Service was a practical disaster, seen both as unfair and ineffective. Criteria for short-listing were just not valid. Disillusioned doctors might lose a year if they fail to obtain the necessary Specialist Trainee posts in this round, and some will leave the NHS and indeed the country as a result. What is regarded as a large surplus of junior IMGs is in the country at present competing for a finite number of specialist trainee posts with the increasing number of UK graduates.

- 2 -

What will happen to them is not clear but it is not likely to be the desirable outcome which brought them here in the first place.

- 3 -

There are other imponderables. Most medical students are now women, and it is now clear that their career paths will be different, with breaks for having children and rearing them. There may also be an increased enthusiasm for part-time work and primary care, rather than whole-time posts with hospital in-patient responsibilities. Serious problems have also been raised about the practical skills of surgical trainees under the new system, which means shorter hours and less chance to conduct operations under supervision in training.

For most British-trained doctors the educational process begins at 'A' level, and apart from veterinary science no profession demands higher grades for what is highly competitive entry to medical school. Our medical students can claim to be the intellectual flower of

the nation. If we cannot use these talents properly it is an indictment of the system.

My scheme for British medical education would be a 4 year undergraduate medical course leading to 2 years' generic postgraduate training in hospital, possibly with some time in general practice. This could lead to a 3 year GP vocational training scheme and appointment at the age of 27 to a permanent post. Alternatively there would be a 7-8 year advanced medical training in hospital, and appointment as consultant at the age of 31-32. There would need to be some flexibility to allow for research and change in specialisation, and to accommodate those who really did not wish to have full time general practice or consultant posts. Continuing in speciality training for more than 3 years would need higher qualifications and assessment of effectiveness. Traditional appointment systems with safety nets for those in difficulty with their preferred careers would be appropriate. A national scheme could be set up for the entire UK, if the separate countries wished.

- 4 -

A medical degree offers a wide choice of career, but we do need to see people working as doctors rather than as pharmacists, nurses or in completely non-medical occupations as occurs in continental Europe. Taxpayers who have paid a six figure sum to put a student through a UK medical school (and the doctor who graduates from one with personal debts!) have a right to expect that they will be the mainstay of the public hospital and primary care service in this country. British medical graduates are an investment for the country. They have been taught in English and exposed to the NHS. They have been supervised by the General Medical Council which has traditionally meant that there is absolute parity between medical degrees in Britain. It is madness not to use this resource effectively, particularly if it means depriving the rest of the world of sorely needed doctors to bolster up our own service.

MALCOLM BATESON
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Bishop Auckland

Organ Donation and Presumed Consent – an Unwarranted Presumption?

In the October 1999 issue of this Newsletter¹ I wrote of my personal view against the concept of *presumed consent* (a so-called 'opt-out' system) for organ donation. A policy of presumed consent would mean that any adult who did *not* wish to donate their organs after their death would *have* to make their feelings known during their lifetime, i.e. absence of consent would mean that consent would be presumed.

The impetus for my comments was the British Medical Association's decision, at its Annual Representative Meeting in 1999, to, amongst other things, lobby Government to introduce a presumed consent scheme in the UK. (A motion in a debate about organ donation that I spoke against with overwhelming failure and found myself in the national press!)

John Hutton, then health minister,

rejected a review or any change in the Government's position.

Since then, we have seen the fallout from Alder Hey, continuing lobbying by the BMA and now support from the Chief Medical Officer. In addition, there have been statements on elective ventilation of patients expected to become organ donors (which the UK Health Departments have stated to be unlawful^{2,3,4} and a non-heart beating donation programme (which has been in place for a few years now).

So, what exactly has changed since 1999?

The BMA published its support in 2000⁵ for presumed consent and the Government published a consultation document⁶ in July 2002 that included the option of presumed consent in the

form supported by the BMA.

It has subsequently also become adopted policy of the Liberal Democrat Party.

The BMA continued to lobby through proposed amendments to the *Human Tissue Act 2004*⁷ (covering England, Wales and Northern Ireland) on its way through Parliament. The Act came into force in September 2006. However, when this received Royal assent it did not include the acceptance of presumed consent, which was also rejected in Scotland⁸.

Importantly, the Human Tissue Act does however make the wishes of the deceased take precedence over those of the family; and this intent was made quite clear in a speech that Rosie Winterton (Minister of State at the

Department of Health) gave to the National Kidney Federation Conference in October 2004 when she had indicated that the Act would *make clear that the consent of the individual, given while alive, to organ or tissue donation, will be paramount. Surviving relatives will not have an automatic right of veto. But in the absence of that prior consent, the Bill will make clear whose consent will be needed for organ donation to proceed.*

Even with this option provided by the *Human Tissue Act* (the ethics of which have been questioned)⁹ it is still considered good practice to consult with relatives and a straw poll of my colleagues suggests that it is highly unlikely indeed that organs would be removed against the wishes of relatives even if the deceased had indicated their wish to do so. Thus, the *Act* does not seem to have changed the *status quo*.

In 2003, Rosie Winterton also announced the setting up of the Department of Health's Organ Donation Task Force¹⁰ that was launched in 2006 with the intent of increasing the number of available organs. But, she was also responsible for restating the Government's view in rejecting presumed consent in a written parliamentary answer in 2005¹¹.

Then, Sir Liam Donaldson, CMO (in England) came out in support of presumed consent in his 2006 annual report published in July of this year¹² in which he points out that although surveys suggest that about 70% of people claim to want to donate their organs after death, only 20% are on the Organ Donor Register¹². The report also claims, as a 'key fact', that consent issues are one of the contributing causes to lost opportunities to organ retrieval (but provides no evidence in support of this claim).

The CMO's position received a fair amount of press coverage, but did not immediately attract any political support from Government or Opposition and it was rejected by the Human Tissue Authority (the Regulator as enshrined in the *Human Tissue Act*) as well as by Harry Burns, CMO for Scotland.

Then, in September of this year, Alan

Johnson requested that the Organ Donation Task Force consider the question of presumed consent (although didn't actually indicate his own views)¹³.

As well as the BMA (whose current view is one of a 'soft' system of presumed consent which *supports a system of presumed consent for organ donation, with safeguards, for those over the age of 16, where relatives' views are taken into account*), supporters do however include a number of influential bodies (Royal College of Surgeons of Edinburgh, British Transplantation Society, Royal College of Physicians). However, significant organisations have adopted a stance against presumed consent (Royal College of Nursing, Patients Association, Patient Concern, UK Transplant, The Human Tissue Authority and the Scottish Transplant Co-ordinators Network. It was also rejected by Andrew Lansley, Shadow Health Secretary).

In addition to these mixed signals arising from various national bodies, the public might well question this whole process of law and policy and how they interact: we have democratically elected law makers plus a CMO whose role is to advise Government; Parliament has already rejected presumed consent, the CMO proposes it again and the Secretary of State suggests it's reconsidered!

The evidence to support an opt-out system is still debated and far from clear, with some countries who have such legislation (e.g. Belgium and Spain) but not all (e.g. Sweden) doing better than us (currently about 19 European countries have such legislation and 8 do not).

The reluctance of clinicians to take organs in the face of family objection has already been demonstrated. It might even prove, in practice, to be impossible.

Presumed consent could do untold damage to the relationship built up by medical, nursing and other staff with the victim's family; it could cause lasting damage to the way our profession is viewed.

Not only would changes to current

legislation be required but, presumably, safeguards would have to be in place for people who do not wish to donate their organs or whose family would be seriously distressed if donation were to proceed.

Can we really be sure that individuals will indicate their wishes and register their lack of consent? It is quite apparent from the fact that there are *£8 billion* unclaimed benefits that people are not always aware of their rights or entitlements¹⁴ (not to mention millions of pounds worth of unclaimed Premium Bond and Lottery winnings). Who will be responsible for checking the opt-out register? How will legislation deal with issues of language, culture and educational capacity for understanding?

My views have not changed since my original article¹ and I sincerely hope that common sense and compassion will continue to prevail.

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