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## Jaw dropping at Council, pursuit of 'independent minds' gone mad and centre stage for the College in medical revalidation

As I write, a primary care trust is, against well-informed professional advice, trying to negotiate a contract for pathology services for general practitioners that will deliver 'results only'. They want to save money by not paying for professional advice on test use and interpretation.

This will of course seem absurd to anyone who understands how laboratory medicine is delivered. Even if requests for help with the interpretation of results were to be rejected (which I suspect would generate a very bad reaction at the GMC), high-level professional input is essential to getting the results right in the first place. Colleagues consistently tell me that, thanks to *'Tomorrow's Doctors'*, today's new doctors are needing more and more basic advice on laboratory medicine, not less. So mistakes will be made. So this is a 'financial saving' that will actually cost the NHS more money, as well as lives.

The 'numbers only' contract was reported to College Council last week, and despite those round the table being well versed in the ways of the NHS, jaws visibly dropped. The contract has not yet been signed and the reactions of those to whom I have since spoken suggest that in all probability (and thanks in part to College intervention) it will not be. But the fact that this proposal has come so far illustrates the danger of degradation of the service if we don't remain vigilant. Although Lord Carter's savings are being demanded with vigour, his warnings are already being ignored.

So the financial problems of the NHS have not gone away, as many of you are becoming painfully aware. But having started the last two President's Columns on that subject, I am happy this time to leave delivering this crucial message mainly to Dr Ian Barnes, National Clinical Director for Pathology, in his article (which is immediately after this column). Please read and act on his words, even if the subject is uncomfortable.

'Against well-informed professional advice', I started with. That seems to be a recurring theme at the moment. Why does it happen? For many reasons, of course. As part of the explanation, there seems to be a widespread belief that important decisions must always be made by independent minds.

'Independent' is a terrible weasel word, widely used in political circles. What does it mean? For most users, *'it means just what I choose it to mean – neither more nor less'* (to quote Humpty Dumpty in *Alice Through the Looking Glass*). But the argument goes that anyone who is closely involved with a system is not 'independent'; so the solution is to have important decisions made only by people who are not involved in the system. If, as a result, they know nothing about the system they are considering, that's regarded as good, because their independence is so much more secure. This flawed logic is, I suspect, behind the widespread (and expensive) use of management consultants in the NHS, as well as indicating that any opinion about the provision of medical care from someone who actually delivers it should be regarded with suspicion. Could this be why the £25 million contract for the new NHS 'Centre for Workforce Intelligence', responsible for planning workforce for the NHS, has gone to the consulting and business services group, Mouchel? Try 'Googling' them. They are described in Wikipedia as providing *'highways, business process outsourcing, water, rail, property, housing, education, energy, waste, environmental and local government consultancy services'*. You couldn't get much more 'independent' of healthcare, could you? This abuse of the concept 'independent' is not universal, but it's widespread; and just because it's widespread doesn't mean that we should stop pointing out that it's stupid. If we accept it, we are complicit in the fallacy.

Speaking of regarding well-informed professional advice with suspicion, I reported in the last *Bulletin* that the Human Tissue Authority (HTA) had failed to replace the three pathologists who had all stepped down from membership of that Authority. At the moment the result of a recruitment process is awaited; but I am aware of several senior pathologists, some with national and international reputations derived largely from their autopsy work, who applied but have not even been shortlisted.

I also mentioned that in August 2009 the HTA had called in the police to investigate events at a large UK mortuary. Not until 4 February 2010 was

it announced that the police had confirmed that – I quote – ‘...the circumstances do not raise a reasonable suspicion of criminality...’. As I had always suspected. Non-compliance with an HTA Code of Practice is not in itself a criminal offence. Now that the threat of criminal prosecution has finally been lifted, I am at liberty to say more. It appears that the HTA called in the police not because they had good evidence of criminal activity, but in order for the police to look for such evidence on their behalf. An HTA document available at [www.hta.gov.uk/\\_db/\\_documents/Papers\\_for\\_Web\\_-\\_2.doc](http://www.hta.gov.uk/_db/_documents/Papers_for_Web_-_2.doc) includes (on page 154) the words: ‘...in many cases, the referral to the police will be for the purpose of investigating whether there is evidence of an offence.’

*Accordingly, the absence of relevant evidence should not be a reason which prevents the Authority from making a referral.’*

So it seems that, despite the considerable investigative powers given to it by Parliament, the HTA has decided that it will call in the police, not to prosecute, but to investigate; even where there is, to repeat the quote, ‘absence of relevant evidence’. This does not seem to me to be a reasonable way to regulate a profession. With support from College Executive I have written a detailed letter to the Secretary of State for Health, politely suggesting that some reforms might be in order. I will report the outcome in due course.

Speaking of regulating the profession, medical revalidation lumbers ever nearer. In England, the main round of piloting the proposals is just starting, at ten sites. If you work at one of them, you should already know about it. Having been involved in the process for some months, I can confidently predict that all will not run smoothly. But that’s no bad thing; for once, these are pilots that are genuinely intended to work out how to do things better, rather than merely setting out to prove that the theory works in practice. The Specialty Standards frameworks developed by all the Colleges (available at [www.aomrc.org.uk](http://www.aomrc.org.uk)) will be amongst many things being tested. We will be looking to make ours better. An external assessor has been commissioned to evaluate the pilots (management consultants again, I’m afraid, though at least they are taking some professional advice) and a cost–benefit analysis will be attempted. Of course, the assessment of cost will be imprecise and the assessment of benefit, in terms of improved healthcare, will be little better than guesswork. But this evaluation matters, because the results will form part of a submission to the Treasury to decide whether medical revalidation will be funded. So I am delighted to report that the Colleges have been promised access to the raw data from the evaluation process. (Are there any volunteers to help to analyse it from the pathology perspective?). Furthermore, it should be possible to get some crude estimate of cost–benefit

ratio at the level of individual components of the process. If the overall cost is as eye-watering as I suspect it will be, there will be data to inform a rational slimming-down. I realise that I am less pessimistic than many of my colleagues about medical revalidation, but I remain hopeful that we will eventually have something that is both manageable and useful.

Of course, the original hope that medical revalidation will ‘catch the next Harold Shipman’ is now recognised to be pie in the sky. But the appointment of Medical Examiners of the Cause of Death, as set out in the recent Coroners and Justice Act, surely will. Shipman famously certified his own murders. No more. Medical examiners will scrutinise every death that is not automatically referred to the Coroner, with examination of case notes and interviews as appropriate, including asking the next of kin whether they have any concerns about the cause of death. Depending on how this is implemented there are many possible benefits beyond catching Dr Shipman. Medical examiners could even reinstate the consent autopsy – if they have time to go through the consent process. They will have an explicit role in clinical governance, and it is interesting to contemplate whether the poor care at Mid Staffordshire Hospital – which is estimated to have caused far more deaths than Harold Shipman did – would have come to light far earlier if an independent medical examiner had listened to the tales of the relatives of the deceased.

My reason for raising this now is that a decision has been made that these medical examiners, who may be recruited from experienced practitioners in any branch of medicine, need a Lead College; and it has been decided that the RCPATH will provide that role. It’s debateable whether this really is ‘pathology’, but it’s certainly investigating the causes of death, which fits quite well with the College Motto (‘Sedes Invenire et Causas Morborum’). The Academy of Medical Royal Colleges thought we would do the job better than any other College and RCPATH Council has agreed. So now we have to decide exactly what to do; what services to provide, and how to pay for them. Medical examiners will need systems for training; a new ‘specialty framework’ for revalidation; CPD services; an audit framework; a forum to share advice and support; and a professional voice. Although not planned at the outset, in time there will presumably be a need for an examination, workforce planning, professional standards; in fact, pretty much all the things the College already does for its members. But how will this be paid for, in respect of medical examiners who are not already Fellows of this College? Affiliate membership is a possibility. But these will all be post-CCT doctors (or equivalent) in their own field. If, in time, an examination

process is developed, could full Fellowship of the College be justified? And 'FRCPath' after the name – along with the higher subscription fee, of course. Or are there alternative approaches? Council will have some interesting decisions to make, but as always I invite your thoughts, especially if you are considering applying for one of the new part-time medical examiner posts, due out sometime in late 2011.

Having discussed professional advice, professional regulation, things going wrong in the health service, murder and the various things your College does for you, I am led inexorably to grab the nettle; your complaints. I do not ignore them. We have just passed the time of year when the College subscriptions fall due. Not surprisingly, having repeatedly discussed falling NHS resources, there have been complaints that College subscriptions have gone up. Permit me a few excuses before I move on to what might be done about the problem.

These complaints are often accompanied by an assertion that 'the College does very little for me'. I hope that reading these pages, and the College 'spam' emails, makes it plain that this is not so; demands for the College to 'do' things are increasing all the time, and (naturally!) we only agree to spend money on things that seem pretty important to me. Revalidation is the latest major example. Being a profession (at least, being a profession that's worthy of the name) requires a professional body, and professional services are not free. One of our main costs is professional examinations – which I hope you prefer to be run by your College rather than by a 'quango' set up by the Government. The demands of PMETB have improved the reliability of our examinations but they have also put the cost of running examinations through the roof. This is exacerbated by the large number of different specialties we cover and by a trend for examination sites to charge for items, such as the use of rooms, that were previously provided free of charge. The Col-

lege's examination fees have increased hugely, as any trainee will complain; yet they have not kept pace with 'examination inflation'. Examinations are now quite heavily subsidised by general subscriptions. Your subscriptions. Is that wrong?

So what should we do? I invite your constructive suggestions. In May, College Executive will be considering this at the annual 'away weekend'. (If that sounds like a holiday, think of a 30 hour committee meeting with time off only for eating and sleeping and you'll have a better picture of it.) We will be looking very hard at how to cut costs. Preferably – as Ian Barnes exhorts us all to do – by improving quality and efficiency. But if – as we fear with the NHS – real cuts are to be made, where should they fall? 'Sell off the wine cellar' isn't an option, as anyone who has visited our new educational facility can confirm. Nor is 'move to cheaper premises', unless you can offer something suitable for a fixed lease of less than £2,000 per year? It's providing services that costs money.

In line with my opening comments about the best advice coming from people who know the system, I'm expecting the best contributions to this debate from those who have held College posts. If you think your College does little for you, if you can't see where your money is spent, could it be that you see too little of what your College does? On page 138 you will find an advertisement for three College Directors, the next Editor of *The Bulletin*, and the College Informatics Advisor. Some of the Regional Councils have vacant posts. If you think your College does nothing for you, why not apply for a post? If you're successful, I'll wager a fiver that when you see what goes on, you'll change your mind within the year.

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## Calling all pathological bibliophiles!

**Do you, or does anyone you know, have any illustrated eighteenth or nineteenth century books on obstetrics which we could beg or borrow?**

For National Pathology Week in November we would like to be able to display some historic illustrations pertaining to mothers and babies. Unfortunately the college has no books appropriate for this theme. We would be very grateful if we could borrow some material for use during National Pathology Week.

The College would also be very grateful for any donations of early books of pathology. We are in the process of rationalising the library, which is predominantly an historical archive, and wish to be able to mount a series of changing displays of early medical illustrations around the College as a permanent feature. We have some interesting books but we do need more. All contributions would be welcome, well looked after and would find a very appreciative home.

Please contact the Honorary Librarian, Dr Mike Addison at [Mike.Addison@manchester.ac.uk](mailto:Mike.Addison@manchester.ac.uk) or Sarah Furness at [shfdesign@pathology.plus.com](mailto:shfdesign@pathology.plus.com)