

On being (and remaining) 'a profession'...



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Sometimes, professionals are their own worst enemies. The meaning of 'professional' has been debated and debased in recent years, but surely an essential aspect of the concept is a degree of self-determination, of self-governance. Members of this College are professionals. We expect and welcome public scrutiny, but within that constraint we will argue that the professionals themselves are best placed to judge what is needed to run the profession and provide the necessary services – in our case, to patients.

This concept is of course challenged whenever something goes wrong – as our Members of Parliament are currently finding to their cost, with daily revelations of expenses scandals being published as I write. The knee-jerk response to an abuse of trust is usually to impose some form of external scrutiny. Doctors always score much higher than politicians in surveys to assess public trust, but nevertheless we have seen the imposition of external scrutiny of our examination and training systems and the introduction of revalidation for doctors, with something similar no doubt to follow for Clinical Scientists. Whether this really builds trust is yet to be seen.

The College remains at the forefront of maintaining the professional voice in the development of pathology services, and I hope you want it to stay that way. To do that, we need your input. That input is getting harder to obtain. Without it, the professional voice will get fainter. I hope that is contrary to your wishes.

These thoughts were prompted by our recent advertisements for Registrar, Assistant Registrar and several Director posts at the College. Thankfully, we have a few high-quality applications for most of the posts. But the number of applicants is small and one of the posts attracted no applicants at all. I am told that this is the latest low point in a long trend. It is linked to the increasing difficulty we have in recruiting CPA Assessors, College Examiners, College Representatives on Advisory Appointment Committees and so on.

Such work has been described by the Department of Health as being 'in the wider interests of the NHS'. I hope that it is self-evidently also 'in the wider interests of the profession', and of patients. Why are people growing less willing to do this work? Several possible explanations spring to mind; increased workloads, staff shortages, greater control imposed by the Consultant Contract,

changes in perception of the role of a professional, changes in expectations around working hours and the European Working Time Directive. Perhaps I should run another web-based questionnaire to dissect them. But a recurrent theme is managers and colleagues expressing the view that doing this sort of work away from your home base is somehow cheating on your colleagues and defrauding your employing Trust, which pays your wages so that you work for it, not for the rest of the NHS. This attitude is as yet far from universal; for example, I am fortunate to have a Trust and colleagues who have without question supported me in spending time to work for the College. But the trend seems to be away from that view.

At my instigation, this matter was discussed using the email system of the Joint Medical Consultants Committee (JMCC) – effectively a discussion forum for Royal Colleges and the BMA, with occasional Department of Health input. As this is itself a body that claims to be an example of 'work for the general good of the NHS', one might have expected a sympathetic response. But one respondent argued that those who do work outside their own Trust are indeed imposing on their Trust and their colleagues, unless they always strive to make their 'external' work bring equivalent benefits back to their Trust to recompense for lost time.

This superficially plausible argument falls down somewhat if you apply it to specific tasks. For example, why would your Trust allow you to act as College Representative on an appointments panel? That's time off to allow you to help the competition ensure it employs the best people. Absurd! Training as a CPA assessor might help your Trust get through the next CPA assessment. But what benefit comes to your employing Trust from you doing assessments? Spying on the competition, perhaps? Or imposing unfair assessments on the competition? This will (I hope) seem a bizarre suggestion to those who currently undertake CPA assessments. But I fear it is the attitude that will in due course be promoted if the ethos of the 'selfish Trust', in competition with other Trusts, is taken to its logical conclusion.

I could go on. The underlying problem is that we work for local organisations, not a 'national' NHS, and those local organisations are now in competition. This is a direct result of Government policy. If unchecked, the logical outcome of this trend is

that not only will any consultant time spent away from your employing Trust be charged for; your time would ultimately be seen as a commodity for your Trust to sell, so external work would become a source of income generation for Trusts.

The consequences would include a large increase in all your professional subscription fees and CPA abandoning the use of peer assessors. There would be a vast increase in examination fees – or alternatively, curricula and examinations would be run by bodies controlled, through their financing, by the Government employing (and thereby controlling) as few expensive pathologists as possible. Look at the recent history of public sector education and examinations if you think that might be acceptable. In all, there would be a dramatic reduction in the profession's input into national decision-making processes and into its self-governance. A profession that loses self-governance loses a key aspect of what it takes to be called a profession.

So there, in a nutshell, is an argument for doing external work and resisting the trend towards 'the selfish Trust'. Of course, as President of a Royal College that relies on the contributions of its Fellows, I would say that, wouldn't I? If you disagree with my analysis, please tell me. But if you agree there's a problem looming, please volunteer to do work 'in the wider interest of the NHS', whether for this College or for other bodies, and support your colleagues who do the same. If your managers object, give us the evidence to argue the case. To do otherwise is short-sighted. Indeed, I'd call it unprofessional.

CPA

The business has now been successfully transferred to UKAS (the United Kingdom Accreditation Service), for reasons discussed before and explained in more detail on page 235. The emphasis now shifts to improving the accreditation system, as demanded by Lord Carter. The College cannot control this process – that's not new – but still has influence. It is interesting that, just as CPA was criticised for being too much under the control of professional organisations, another part of the Department of Health approached the Academy of Medical Royal Colleges to consider developing and co-ordinating systems of clinical service accreditation across the health service. Even as CPA was being criticised, the College was being asked to lead this process, because we have by far the longest experience of clinical accreditation systems. This development is linked to the 'quality agenda' arising from Lord Darzi's reforms and to the establishment of the new Care Quality Commission. The Darzi 'quality metrics' so far proposed make almost no mention of diagnostics. This is no surprise; at risk of oversimplification, how could an approach based on 'patient pathways' evaluate the processes that decide which pathway a patient is to join?

A meeting is planned at which those who provide clinical accreditation services will discuss how the existing and nascent accreditation schemes might be modified to satisfy the needs of all those who need information about service quality, including managers, commissioners, the Care Quality Commission and – of course – patients. It is also hoped that those who have to regulate very specific aspects of the service, such as the Human Tissue Authority and the Medicines and Healthcare products Regulatory Agency (MHRA), might agree to respond to the increased independence of CPA by allowing a single but sophisticated accreditation inspection to inform their decisions, rather than imposing multiple overlapping inspection processes. The result could be just one inspection that generates different reports on different aspects of the service for the benefit of different 'users'.

Plans that are intended to decrease bureaucracy are commonly proposed and usually seem to fail, but this one is surely worth a try.

The link to NHS commissioning

Improved laboratory accreditation is also, in my opinion, important for the introduction of NHS commissioning and responding appropriately to pressure for increased involvement of the private sector. Lord Carter warned of the danger of commercial organisations 'cherry-picking' the high-volume, lucrative parts of the service and thereby destabilising the rest. How might newly appointed commissioners be persuaded not to fall into this trap, especially as financial pressures mount? They need to understand that pathology is, as Lord Carter pointed out, an 'end-to-end' service, from the decision to request the right test to the correct interpretation of its result. They will not get that information from an accreditation process that is – it is alleged – too focused on evaluating processes and quality manuals, and not focused enough on patient outcomes. Surely it would be more helpful to commissioners to have an accreditation system that looks at the whole of the 'end-to-end' service? Should we not put more emphasis on sustainability – not just maintaining staff skills, but insisting on a contribution to training the next generation? Furthermore, is it sensible in this new context to have a system for quality evaluation with a simple 'pass/fail' outcome? Would it not be better to include some more quantitative measurements of quality in key areas, perhaps something closer to 'benchmarking'? The Department of Health has made it plain that laboratory accreditation will not be mandatory. But I believe that if we can make the results more helpful to managers and commissioners, the outcome will be close to the one we want. How else can we persuade commissioners that there's more to laboratory quality than low price and fast turnaround times?

The rest of the world exists too

Mea culpa. In writing this I have so far been far too UK-centric – even too England-centric. But about 2000 of the College's 8800 members live and work outside the UK. They are widely distributed, so maintaining contact and delivering useful services to them all is difficult. I have discussed the recent College communications survey in a separate article on page 233, but one of the clear messages from that survey is that it's not just Government-imposed changes in UK immigration rules that are causing dissatisfaction amongst overseas Fellows and trainees. Much of what I have said so far reflects the fact that the College is under increasing pressure from the UK Government to address the needs of the UK health service. Our curricula and examinations have to be approved by the Post-graduate Medical Education and Training Board (PMETB) as being fit for UK use. Our CPD scheme is currently under scrutiny to assess its relevance to new UK revalidation processes. All this risks making the services we offer less relevant outside the UK. To counter this, should we attempt to develop Fellowship examinations that lack the UK emphasis (and are not controlled or recognised by PMETB) but are more relevant to other parts of the world? Should we organise College representatives to oversee local CPD schemes around the world? Such suggestions have resource implications that, to put it mildly, raise the eyebrows of the College Treasurer and the Directors of Examinations, Training and Professional Standards. How can we do these things to an acceptable standard and balance the books? Opinions please.

Finally, I can't resist a comment on...

... our UK politicians, who as I write are suffering a 'media storm' resulting from the publication of their excessive claims for expenses. To be fair, it is a tribute to our system that they failed to keep the scandal hidden; there are too many parts of the world where keeping such facts secret would be all too easy. But, with tongue firmly in cheek, consider some parallels with pathology.

On page 198, Professor Sir James Underwood reviews the consequences of a time, not too long ago, when one pathologist (at Alder Hey Hospital – a man who, it cannot be said too often, was not a member of this College) did things that were outrageous, even if not strictly unlawful. Many colleagues were then found to be doing things that were in accordance with the rules and practices of the time, but that nevertheless caused outrage when made public, because the rules and practices were out of step with public opinion. The political and media frenzy that followed attacked and demoralised us all, including those with no involvement in post-mortem work. Of course, the analogy does not stretch too far. We recognised the foolishness of trying to cover up mistakes. We did not try to hide things; we collaborated fully with the inquiry. We were doing work for the good of patients and the public health, whereas the motives of our MPs you can assess for yourself...

But at least now all our MPs must know what it feels like!

Many observers – including politicians who ought to know better – have recently referred rather grandly to 'The court of public opinion'. That's too simple. That fine-sounding institution has another, less appealing name. It's called the lynch mob, and history gives it an even worse press than our politicians are now getting. It might be worth pointing out to MPs and to the press the lessons teased out by Sir James; that an emotional response to public outrage, imposed in haste and in a spirit of retribution, can have long-term disadvantages that are difficult to correct.

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Speak up: give your view on College consultations

All College documents affecting pathology practice are put for consultation on the website.

Please send us your views.

Just log in and visit
www.rcpath.org/index.asp?PageID=90

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