

Spheres of medical influence: *President, Royal College of Physicians*

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I have been asked to describe ways in which, through the Presidency of the Royal College of Physicians (RCP), it is possible to influence developments in medicine in its broadest sense, for the better.

It is given to rather few people in medicine to make a decisive impact upon thinking and action by virtue of the appointment they hold. Of course, outstanding individuals, both in medical science and service have done so in memorable instances. But that usually reflects their singular talents rather than the post they happen to occupy.

I shall not lay claim to any particular achievements; rather I shall describe the opportunities that Presidency of this College brings to influence affairs. Some of those opportunities are open solely to a President, as a participant in deliberations at certain levels of policy and decision making; but many more are given to any among us who are prepared and have the will and drive to change things. Opportunities are not awaited passively; they are to be seized and created too.

Many of the opportunities open to a President arise out of the standing of the College, through recognition of the values it upholds, the commitment of the Fellows and Members and the quality of their contributions to the enterprise to improve health and healthcare. It is a prime duty of the President to maintain that standing.

The collegiate influence

It is rather easy for a President to give the wide and lofty view. What I suspect most readers will wish to have are views from those who have actually led and have done most of the work on which the President can, indeed must, draw.

At times almost all Fellows and Members contribute to intelligence and data collection. Almost continually several hundred, as well as others who support our work and purpose, participate in the work of the College, in its Council, work on education, standards and clinical performance, 'think tanks' and the necessary, if less conspicuous, efforts of business committees that give order and support to the task. All are working to influence medicine for the better. Opportunities present themselves daily within the life and work of the College and its colle-

giate body, where much thinking takes place, diverse experiences are brought together and the most promising or challenging ideas are worked up.

The President is in a position to draw attention to the work, targeting it, repeatedly if necessary, towards people who recognise its significance and where it may have greater impact.

The President's role

During the first year of Presidency I thought it proper, indeed necessary given today's expectations of accountability, to define the role and strategic objectives of the President and to introduce a system of appraisal. This is no more than is required for every senior doctor, health service manager or civil servant. The exercise and continuing reflection on the goals set have also served to keep balanced attention to all aspects of the role. They have also encouraged a searching view of opportunities that are the subject of this article.

The principal role of the President is to provide leadership to and represent the RCP and the medical profession at national and international level. No less important is the reminder that the President is a member of a corporate team, working to and within the overall strategic direction and goals of the College. The strategic objectives during my Presidency are set out in Fig 1.

The duties and responsibilities of the Presidency confer the extraordinary privilege of being able to

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SPHERES OF MEDICAL INFLUENCE

The clinical career of most consultant physicians is structured with regular ward rounds, outpatients, procedures, teaching and administrative work often maintained throughout a consultant career spanning some thirty years. Each tenure is a miracle of persistent achievement. Others combine original academic or managerial work alongside their clinical commitments.

A few serve in a wide range of key posts, contributing at the national or international level. This new series, through the pen of each of these individuals, describes how medicine can be influenced in its broadest sense for the better.

The series opens with a positive, constructive and wide ranging contribution from Professor Dame Carol Black, President of the Royal College of Physicians 2002-2006. Her acceptance of the original invitation has persuaded others to follow suit. We are most grateful and much in her debt.

draw on the talents and wisdom that abound among the Fellowship and Membership, and the elected and appointed post holders. One simply cannot do the job well without the well-prepared support and considered advice that the College and the collegiate body are able and willing to give.

What has become increasingly and now vividly obvious to me during the past few years is that it is both a responsibility and a privilege to be the public voice of a great collegiate institution, an institution that contains many thousands of able people, many of quite remarkable ability and commitment. Their commitment to the vast and humane enterprise of medicine and medical science is for the most part rather modestly undertaken. They do not boast or shout about their achievements; indeed at times some observers might conclude that reported improvements in health experiences and outcomes are the direct result of efforts remote from the clinical scene.

I have remarked that the role of a President has two faces: one looking inwards to people and societies the College seeks to represent; the other external, seeking to influence and shape events in ways that satisfy our convictions, aims and aspirations; in short, our values. Each view informs the other.

Influence through the collegiate body

A number of events are crucial to this exchange, notably the programme of regional visits to trusts where physicians and managers work. They tap a rich source of knowledge, experience and judgement, particularly of the impact of current, often turbulent changes and the professional challenges they bring. When drawn together they form a coherent insistent picture; they are far more than local anecdotes.

Meetings with trainees yield vital and compelling views. For example, among major points gathered from trainees is that good training opportunities are available, but often they cannot take advantage of them. Such are the demands of acute medicine that to complete their work on the ward and comply with the

Give leadership to Fellows, Members and other physicians, and the staff of the College, working with them and external stakeholders to improve health and healthcare:

- maintain and strengthen the role of the College in setting standards of training and practice in internal medicine and its specialties, in academic medicine and clinical research, and in improving health, in the UK and abroad
- seek to influence policy development and implementation that have implications for the College, physicians, and for patient care
- maintain strong working relationships with national decision-makers to ensure optimal influence for the College
- promote partnership with patients and carers
- maintain and strengthen the governance and internal working of the College, ensuring that it operates effectively in a changing environment
- ensure the financial strength of the College
- maintain personal professional standing.

Fig 1. President's strategic objectives.

European Working Time Directive (EWTB), trainees often must choose between clinical work and a teaching session. Inevitably, clinical work has commanded priority. Moreover, pressure of work also means that they often miss outpatient teaching opportunities, limiting their experience of the range of medical specialties and gaining a distorted and restricted impression of the range of modern medical practice.

Where such views and experience are widespread they point to serious problems that need to be addressed and corrected. College Officers and I make the point in meetings with Ministers and officials, and through the bodies with training responsibilities.

Influence through specialist societies

Being able to listen and to speak at meetings of specialist societies has been extremely important to me. I have been keen to show how the College works externally for the larger common concerns and interests of medicine – its overarching role. By that I mean its role in representing physicianly medicine, the skills that physicians bring to bear in the health service, their motivation, their inventiveness, their willingness to lead and bring about change when it benefits patients – improving the effectiveness of clinical care and making it safer. I am clear that the integrity of internal medicine as a whole is often best ensured by working with and through the College. I believe the College can support specialty interests, generally representing them, often collectively, more strongly and more effectively, at significant and often decisive levels of influence – not just Government, the Department of Health and NHS organisations, but also in a variety of more open forums.

Collaborative influences

Within the College, continuing work on standards, education, clinical performance and continuing professional development provides the strongest assurance of our role and source of influence.

There are many examples. Each brings out the collaborative, interspecialty, multidisciplinary approach that is characteristic of our work today. It is the kind of approach that the College is now well designed to foster. Each shows how by working through the College we can best ensure the integrity of internal medicine as a whole within today's health environment.

Establishing the patient and carer network and its Steering Group has been a most important step. It has brought together people who are able to represent the views and interests of patients and carers with those of the College, with opportunities never available before, to inform and influence all our thinking, views and policies.

Wider influences

A term used to describe our relations with other organisations – and there are many – is partnership. A score of professional, regulatory, managerial and national independent institutions influence what we are able to do (Fig 2). The widening range of

our encounters are steps towards a richer dialogue necessary to influence the many agencies with interests and influence in matters that, even if once guarded as professional territory, are no longer solely our own.

An insistent theme, variously arising from the General Medical Council, Postgraduate Medical Education and Training Board, the Healthcare Commission, work with the specialist societies on standards, our audit work, the requirements of clinical governance, performance assessment and revalidation, has to do with standard setting and the quality of care. Our engagement in every one of these areas serves to heighten the central role of the College in supporting every Fellow and Member conduct these professional activities that are now an essential part of the physician's life. It is a powerful influence that as President I make known whenever it should be heard.

This is just one example of the College being able to act on behalf of physicians and medicine, for patients, in ways that that other bodies are really not constituted or driven to do.

Our first Open Day in the summer of 2005 demonstrated to a wider public that our overriding purpose is to improve health and healthcare and to do so by working in partnership with public and patients. This may sound obvious, but it represented a radical departure from the way we worked, and were seen as working, in the past.

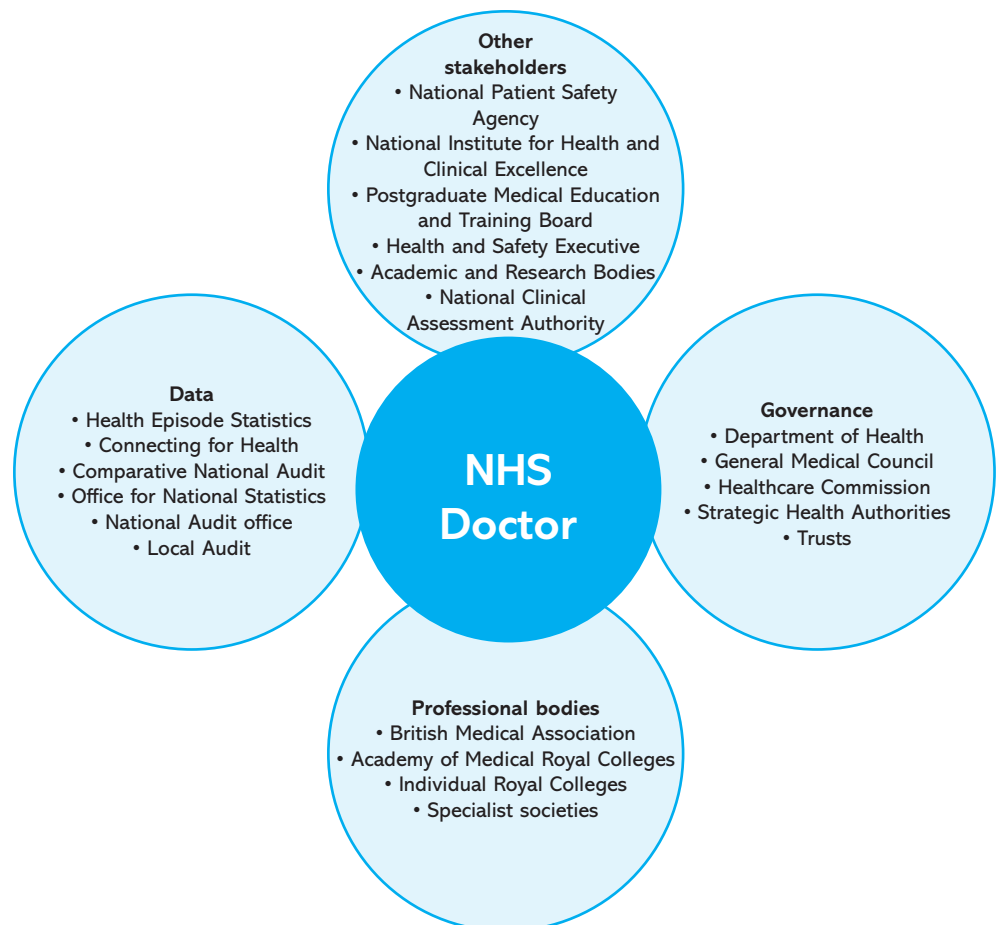
Influence through Government

The President must maintain strong, frank, working relationships with Ministers and officials, making clear how we stand, where we can give support, where we differ and can offer legitimate and fruitful alternatives. Sometimes there must be compromise, with decisions that may prove unpopular. There must be consistency and the integrity that underpins trust. Civil relationships must be maintained across the fiercest differences.

There are events that are not easily influenced: those governed by political timetables, for example, the pace of reform. Often the implications and possible consequences of many policies are not foreseen or thought out in detail. It is here that a difference can be made, and an amending influence brought to bear.

An obvious and very important example arose out of the implementation of the EWTB. In preparing for implementation, the Department of Health worked with the profession to explore ways of alleviating some of the consequences, for example by examining new ways of working based upon changes in skillmix and new kinds of healthcare professional. Besides a concern that these untested approaches could not yield effective solutions in the near term, however, we recognised that there were few data to inform planning of duty rotas and shifts to ensure the safety of patient care, alongside training needs of

Fig 2. Wider influences: external relations. Examples of groups of stakeholders interested in national regulation and standards.



doctors and their legitimate claims for the quality of their personal lives. Again the College chose to take up the task.

Influence through Parliament

There have been, and will certainly continue to be, important opportunities to give written and oral advice to Parliamentary Select Committees. They have proved to be a responsive and influential force for the benefit of medicine, practice and health. Supported by colleagues, I have led for the College in providing evidence on a number of significant and sometimes pressing matters that bear on medicine and public health. For example, the full implications of the EWTD for health services, compounded by restrictions imposed by the Sindicato de Médicos de Asistencia Pública ruling (an EWTD) and Jaeger judgements of the European Court of Justice, were not fully appreciated. We were able to provide comprehensive evidence from surveys, for which the Fellowship provided data, to a Lords Select Committee. That Committee made its concerns strongly heard, prompting vigorous Government and NHS action.

Other recent examples are evidence given to the Health Committee Inquiry on workforce needs and planning for the health service; on the inquiry on Independent Sector Treatment Centres; on the Public Health White Paper; and on passive smoking. And there has been a close dialogue on the Assisted Dying for the Terminally Ill Bill.

To reinforce the opportunity offered by a free Commons vote on a smoking ban, the Presidents of the UK Colleges of Physicians wrote to every MP, urging them to vote to ban smoking in public places. The outcome was the one for which we had argued.

Influence through NHS management

I have found that my meetings with managers, both medical and non-medical, lead to discussions that in some areas are similar to those with clinicians. They dwell on such familiar topics as the consequences of the EWTD, problems surrounding the acute medical take and emerging solutions, threats to continuity of care, informed commissioning, the interface of primary and secondary care, financial problems, and so on.

At every opportunity I have pressed the challenge as to whether the NHS culture has really accepted clinical leadership; that is, a real place for clinicians as leaders. How can we ensure that clinical leaders have a part in policy development and implementation throughout the NHS, in primary and secondary care jointly? Introducing new clinical developments, service organisations, and building and maintaining effective clinical networks depend crucially on clinicians; they always have.

I have clearly and firmly represented the view that heightened clinical engagement and partnerships at every level are essential if the aims of reform are to be achieved. Such partnership has been crucial, for example, in overcoming service problems incurred by the EWTD, in work to improve the safety of care of acutely ill people, in supporting the development of

Modernising Medical Careers and in work to strengthen clinical leadership.

Some of the consequences of reform present challenges that will be difficult to address without fuller clinical partnership than has been evident so far – for example, concerns about effective commissioning and service redesign, the need for collaboration alongside contestability; demand management; and more pressing than ever, a better understanding of alignment of clinical and financial responsibilities.

A notable and successful example is our doctor–manager programme, which the Chief Medical Officer has commended in the warmest terms. Working together on specific problems has enhanced understanding of each other’s responsibilities, priorities and motives. We believe, though cannot at this stage demonstrate, that the experience will influence behaviour well beyond the participating individuals. Moreover, I suspect such collaborative working matches and harnesses the inherent motivation of clinicians more readily than any contractual influence.

Independent influences

There are opportunities to witness and participate in the deliberations of distinguished people, people who stand apart from our immediate preoccupations, people who offer a new frame, who bring a wider perspective for our concerns.

Some independent influences are more direct. A recent powerful example has been the work that led to the College Report *Doctors in society: medical professionalism in a changing world*.¹ Membership of the working party extended far beyond the College, and it took evidence from many witnesses, all eminent in their different fields. Among its chief aims the Report sought to provide a common understanding of the values of medical professionalism and echoed the view of the Healthcare Commission that clinicians are also ‘the main agents of improvement’.

The variety of these encounters has encouraged me to draw together the different strands of larger themes, often with the aim of putting them into broader policy contexts – both of government and of the profession. Their consistency gives them weight beyond anecdote. They are valuable both for informing deliberations and aligning priorities within the College and for guiding my regular discussions with Ministers and senior officials.

This in turn has given new emphasis to the leadership, management and advisory functions needed to support the work of a President and – more broadly – to enable the College to assert the influence necessary to protect its role in safeguarding clinical standards at a time of relentless change and reform. It is reflected in the steps taken to modernise the College, with strengthened external networks to develop a clearer understanding of the political, social, academic and management drivers of policy, and the concepts and evidence that underlie them.

Personal influences

Besides the corporate influence the President works to serve, there are opportunities to make more personal observations. The President’s columns in the Commentary are examples although I

do not know to what degree they influence thinking. Their chief aim has been to give a view of events and trends that seemed at the time among the most significant for the College and to help keep the collegiate body both informed and engaged in, and therefore better able to influence, affairs even from a distance.

From time to time the President is asked to lecture on a broad topic, open to individual treatment. This provides opportunities to explore emerging themes, necessarily taking care in such circumstances not to stray from agreed positions. For example, a Donald Hunter Lecture provided me with a timely opportunity to consider the impact of common disorders on employment and the challenge it presents to various agencies including health services and to the goals of clinical practice. Out of this flowed work by the Academy of Medical Royal Colleges on the return to work as a measure of outcome following medical intervention.

More formally, the annual Harveian celebration provides an opportunity for the President to signal the evolving stance of the College on significant issues of the time.

Conclusion

I have outlined ways in which it has seemed to me possible to influence developments in medicine in its broadest sense, for the better. That influence represents the values of the College and the profession and the continuing demonstration of our commitment and willingness to work by and for those values. They are values that matter to patients – those that define the quality of their care.

With few exceptions I have deliberately not listed the achievements of the College. They are not mine and I hope that in succeeding papers other authors will feel able to give accounts of the influence they have brought to bear, shaping thinking both within the College and beyond, about developments in medicine that can be for the better.

Reference

- 1 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. Report of a Working Party of the Royal College of Physicians of London. London: RCP, 2005.