FOR THE RECORD

United Kingdom's General Medical Council urges reforms

In a bid to improve physicians' "cultural awareness and knowledge of what the NHS (National Health Service) is and how it operates," the United Kingdom's General Medical Council (GMC) says it will establish a national basic induction program to school all new and overseas doctors who set up a shingle in the UK.

"Doctors who have been trained in the UK have been exposed at an early stage to professional standards and UK healthcare systems. More needs to be done to ensure consistency of induction for overseas trained doctors, so that they can gain an early understanding of the ethical and professional standards they will be expected to meet, as well as familiarity with how medicine is practiced in the UK," the general medical council states in its first annual report on *The state of medical education and practice in the UK* (www.gmc-uk.org/State_of_medicine_Final_web.pdf_44213427.pdf).

"While there are some good local schemes for supporting doctors who are new to this country, there are too many examples of new doctors undertaking clinical practice with little or no preparation for working in the UK. There have also been accounts of locum doctors being sent to undertake duties for which they have not been appropriately trained. As a contribution to help support doctors who are new to UK practice, we intend to work with employers and professional organisations to develop a basic induction programme. Ideally we believe that all doctors should have to complete the programme before they practise, whether they are trained in the UK, elsewhere in Europe or further afield as everyone who treats patients needs to be supported to do that safely," the report adds.

A lack of familiarity with UK systems, including the "ethical framework in which healthcare is practiced," a lack of training in communications skills and lack of facility in the English language are among the major difficulties that some new doctors face and for which more training must be provided, the report states.

The report indicates that about 12 000 doctors start working in UK each year and that an estimated one-third of those garnered their medical credentials abroad, including about 10% from nations in the European Economic Area. Some 37% of the 239 270 on the UK register were trained abroad. India is the leading producer of foreign-trained physicians now practising in the UK, with 25 762, followed by Pakistan (8104), South Africa (6176), Republic of Ireland (4053), Nigeria (3572), Germany (3432), Egypt (2992), Sri Lanka (2423) and Iraq (2301).

Registered male doctors (139 381 or 58%) currently outnumber female doctors (99 889 or 42%) but the latter are expected to overtake the former between 2017 and 2022. Male doctors are more likely to have complaints registered against them (by a 75% to 25% count in 2010). "In 2010 the top three types of concerns were about: clinical investigations or treatment; respect for patients; and communication with patients."

The report also argues that there is a need to reduce existing variations in the way physicians practise in the UK, particularly in the provision of care at hospitals or in the treatment of children or patients with dementia or cancer. "The evidence from the UK and around the world is that there are significant differences in patterns of treatment and outcomes and many of these are unexplored and unexplained."

There is also evidence that "some doctors are falling seriously short of the standards expected of them," the report adds. "Categories of concern" include:

- "Clinical care: investigations or treatment; record-keeping; patient assessment; patient examination; use of resources; treatment in emergencies; consulting colleagues; recognising limits of personal competence
- Probity: criminal conviction; conduct; financial and commercial dealings with patients; conflicts of interest; writing and signing reports and documents; informing the GMC of charges or offences
- Relationships with patients: effective communication; respect for patients; treating patients with dignity; consideration for family and carers; confidentiality; being open and honest if things go wrong
- Working with colleagues: working in teams; respect for colleagues; sharing information; reporting concerns about colleagues
- Health: mental and behavioural illness; physical illness; adapting practice when ill
- Maintaining good medical practice: keeping up to date; maintaining and improving performance
- Teaching/supervision: honest assessment and appraisal; appropriate supervision; references and reports; appropriate audit and peer review
- Compliance with GMC investigations: failure to comply with assessment." — Wayne Kondro, *CMAJ*

International panel says CIHR should periodically review mix of institutes

Periodic review of the lineup of its institutes, larger and longer grants and improved metrics are among measures urged at the Canadian Institutes of Health Research (CIHR) by a blue-ribbon International Review Panel (IRP) struck to assess the agency's performance through 2010.

"The Governing Council [GC]

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should form a working group to periodically (every 3-5 years) examine whether the slate of CIHR Institutes is appropriate," the 11-member panel, chaired by Dr. Eliza Zerhouni, president of global research & development (medicines and vaccines) for sanofi-aventis, recommends in its *International Review Panel Report 2005-2010* (www.cihr-irsc.gc.ca/e/documents/irp_2011_e.pdf).

"Although the IRP considers the current slate of mandate-specific Institutes to be appropriate, the IRP noted the importance of a periodic review of the composition of the Institutes to ensure that emerging areas of science and public health needs are met over time," the report adds.

Overall, the panel report delivered a more positive view of CIHR operations than that offered by a predecessor panel in 2006, which concluded that while the science supported by CIHR was excellent, many of its operations were overly complex, incoherent and chaotic (www.cmaj.ca/lookup/doi/10.1503/cmaj.061162).

Not that CIHR emerged entirely unscathed from the exercise, as its peer review systems, grant policies and metrics were again found to be in need of reform.

"The proliferation of committees and reviewers needs immediate attention to ensure the continued health of the process," states the report, which was presented to CIHR's governing council in June and posted on the agency's website over the course of the summer. "In addition, the IRP suggests that strategic changes to the grants policy, such as awarding larger and longer grants and creating a regular and more formal process for research program portfolio planning, would enhance the efficient and effective performance of the research enterprise in Canada The 2011 IRP reiterates the recommendation of the 2006 Panel in calling for the creation and collection of objective and substantive metrics and data at all levels of the enterprise. Such efforts will help ensure that future reviews of CIHR activities are based on a comprehensive data set, thereby informing future course corrections and resource allocations."

Among other recommendations made by the panel:

- "CIHR should consider awarding larger grants with longer terms for the leading investigators nationally. It should also consolidate grants committees to reduce their number and give them each a broader remit of scientific review, thereby limiting the load and ensuring full attention to new highly meritorious proposals.
- Conduct regular and comprehensive planning efforts to define and prioritize targeted research areas and create and promulgate research announcements aligning with these priorities. Consider creating a Common Fund from which some of such announcements could/should be funded.
- CIHR should develop a comprehensive set of metrics and robust evaluation strategy as a means of regular review of CIHR by both the agency's leadership and future international review panels.
- Expand the breadth of the members of the Governing Council to include public members. The formation of a parallel advisory structure that would enlarge the participation of voluntary organizations may also be considered.
- CIHR should explore methods for increasing public and patient participation/input in all its processes from prioritization, through advising on appropriate study endpoints and funding decisions to trial steering groups.
- CIHR should lead a Canada-wide effort to harmonize data sets and enable national linkages which would benefit all CIHR institutes and the Canadian research enterprise at large.
- Establish Canadian Centres of Excellence of Clinical and Translational Research, which will develop the critical mass of scientists coupled with research infrastructure (horizontal integration) to expedite the advancement of basic discoveries to human application, impact clinical practice, and community health."

The IRP also expressed satisfaction with developments at CIHR in response to the 2006 recommendations. "The governance structure for research has been significantly improved. The Governing Council is now responsible for setting overall strategic directions for CIHR and approving its budget reports to the Minister of Health. The mission and function of the Governing Council have been improved by the current CIHR President. As suggested by the 2006 IRP, the Scientific Council, which is made up of the thirteen SDs [scientific directors], is providing scientific leadership and advice to the GC on health research, knowledge transfer priorities, and strategies in accordance with the overall strategic directions set by the GC," the report states.

But peer review and a measure of chaos remain problems, it adds. "Although some progress has been made in shaping the review structure within CIHR, it is clear that the agency still suffers from excessive complexity in its grant programs. A proliferation of grants committees to support its programs leads to a combination of confusion amongst scientists applying for grants and severe review fatigue. Previously identified in the 2006 Review as a growing issue, this remains a problem which threatens the entire system of grant funding. It is not clear how best to resolve this problem, but the proliferation of committees and reviewers suggests that they are being asked to look at too narrow a set of scientific grants and that the size of the average grant is sufficiently small that many grants need to be awarded and administered. In addition, the number of times an applicant can submit previously rejected projects is unlimited, creating potentially unnecessary 'churn' and workload which may gain by being streamlined. Several new investigators pointed out that three-year grants were too short to establish a competitive program and welcomed the intent to lengthen these grants to five years." — Wayne Kondro, *CMAJ*

The changing face of family practice

Roughly 30.5% of family physicians/general practitioners now consider themselves as having a "specified special focus to practice," according to the *2010 National Physician Survey*.

Of those, most are focusing on emer-

gency medicine (25.8%), followed by geriatric medicine (9.1%), obstetrics (8.9%), palliative care/palliative medicine (5.9%), anesthesiology/anesthesia (5.0%), hospitalist care (4.0%), addiction medicine/substance abuse (3.9%), occupational medicine (3.5%), psychiatry (3.1%) and psychotherapy (3.1%). Some 1.2% said their focus is on "alternative/complementary medicine." Roughly 6600 family physicians were among the 12 076 (18%) of Canada's 66 906 physicians who responded to the survey conducted by the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Canadian Medical Association (www.nationalphysiciansurvey.ca/nps/2010_Survey/pdf/en/downloads/NPS2010-National-Binder.pdf).

There has been an increasing trend toward such focuses in family practice in recent decades as a result of the perception that doing so yields financial benefits and more latitude to blend lifestyle considerations, such as raising a family, into their practice. But in some instances, a focus necessitates additional training requirements.

Some 5.2% of family doctors say they focused their practice over the past two years, while 9.6% say they plan to do so in the next two years.

Other highlights of the 2010 National Physician Survey are:

- 17.5% of family physicians said their practices are accepting new patients, while 40.8% say their practice is "partially closed." On average, the family doctors have about 1701 patients on their roster.
- 7.2% of family doctors said they see more than 175 patients per week, while 5% said they see more than 200. On average, the family doctors said they see 107 patients per week.
- 21.5% of family doctors said they keep electronic records for their patient care settings, while 40.7% use only paper charts. (The remainder use some combination of the two, did not respond or said they do not provide patient care).
- 19.5% and 6.9% of family doctors, respectively, rated their patients' access to specialists as either "fair" or "poor." The toughest nuts to crack? Psychiatrists, followed by orthopedic surgeons, dermatologists, mental health workers and psychologists. Conversely, 15% and 12% of specialists rated their patients' access to family doctors as fair or poor.
- 17.3% and 10.6% of family doctors, respectively, rated their patients' access to urgent care in hospitals as fair or poor, while 14.0% and 8.1% of specialists put their patients in the same categories.
- Some 46.7% of family physicians said they spend 21%–40% of their gross income on staff, mortgages, equipment, professional fees, malpractice dues, overhead or other costs associated with running a practice. Some 27.8% spend 20% or less, and 8.8% said they spend more than 40% of their gross income on such outlays, while 15.4% either do not have such expenditures or did not respond.
- 47.7% of family doctors said they are in some form of group practice.
- 57.8% of family doctors and 28.5% of specialists said they see "urgent" referrals on the same day. Meanwhile, 34.7% of family doctors and 8.4% of specialists claimed they see "non-urgent" referrals within a week. The mean wait time for nonurgent referrals to see family doctors is 3.27 weeks, while that for specialists is 11.87 weeks.
- 7.4% of family doctors said they offer "alternative/complementary" medicine to their patients.
- 7.1% of family doctors said they never read a peer-reviewed journal and 4.3% said they do so but once a year.
- 40% of family doctors derive more than 90% of their income from fee-for-service payments, while 34.8% do so from a blend of fee-for-service and other form of payment, and 7.6% are salaried. — Wayne Kondro, *CMAJ*

Wishful thinking

Lower debt loads, group practice and a better work–life balance top the wish lists of Canada's next generation of doctors, according to the *2010 National Physician Survey*.

Some 13.9% of 2546 residents, and 6.9% of 3138 medical students, estimated that their debt upon completion of residency or medical school will top $160 000, according to the separate surveys of residents (www.nationalphysiciansurvey.ca/nps/2010_Survey/pdf/en/downloads/NPS2010-residents-full.pdf) and students (www.nationalphysiciansurvey.ca/nps/2010_Survey/pdf/en/downloads/NPS2010-students.pdf). Roughly 13.8% of residents said they'll carry a debt load of $100 000–$600 000, while 17.1% said they'll have no debt whatsoever. By comparison, 20.5% of students fell into the former category and 9.3% into the latter.

The residents also indicated that, for the most part, their level of debt did not influence their choice of medical specialty. Just 8% said they chose a specialty because of anticipated lucre. But medical students appear more prone to such considerations. Some 19.4% say they'll handle their debt by chasing the best-paying specialty. Meanwhile, some 19.6% of the students said they will "practice where offered an incentive."

Some 2.3% of family medicine residents, and 7% of specialists, say they plan to hightail it to the United States in search of big bucks to pay off their debt. Meanwhile, 2.8% of medical students say they'll head south of the 49th parallel because of their accumulated debt.

Roughly 68.2% of 666 family medicine residents, and 58.4% of specialty medicine residents, say they'll seek some form of group or interprofessional practice once they complete their residencies. Just 1.5% of family medicine residents and 3.3% of specialists plan solo practices, while the remainder are undecided or did not respond.

Asked to identify the single most important factor "for you to have a satisfying and successful medical practice," 49.7% of residents said "work and personal life balance," followed by "sufficient medical competence" (17.8%) and type of practice environment (9.6%). Just 1.4% identified "ability to achieve desired income" as their prime motivator.

A slightly higher percentage (53.4%) of medical students identified work–life balance as their most important consideration, followed by "sufficient medical

competence" (23.1%). Just 0.6% had income levels in mind.

Other highlights of the residents and medical students components of the 2010 National Physician Survey are:

- 45.5% of residents, and 53.6% of students said "earning potential" led them to choose a career in medicine, while 22.3% or residents and 27.7% of students said "prestige" was a motivator.
- 9% of 666 family medicine residents say they plan to provide "alternative/complementary medicine" in their medical practice.
- 74.3% of those family medicine residents say they plan to practice as a family physician but 3.9% do not and the remainder are undecided or did not respond to the question.
- 31.8% of the family medicine residents plan to focus their practice in a specific area.
- 81.5% of family medicine residents, and 75% of specialists, plan to use electronic medical records in their practice.
- 48.3% of students said they will select family medicine as their area of specialty, followed by internal medicine (22.3%), emergency medicine (21.4%), pediatrics (19.9%), obstetrics and gynecology (11.8%), general surgery (10.1%) and cardiology (7%).
- Just over 15% of medical students came from families whose total annual income averaged less than $60 000.

Some 3139 or 29.5% of the nation's 10 627 medical students, and 2546 or 20.3% of Canada's 12 546 residents, responded to the survey, which is considered statistically accurate to within +/- 1.7% for the students, and +/- 1.9% for the residents, 19 times out of 20. — Wayne Kondro, *CMAJ*

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