LIFE AND DEATH **Iona Heath**

# How can we learn from the killing of David Gray?

## The opacity of EU legislation may be a smokescreen for apathy

General practice can feel very lonely and nowhere more so than in a strange house in the middle of the night with a patient one has never met before. The range of diagnostic possibility at this first point of contact is enormous and help and advice not easy to come by. What sort of economic pressures or professional aspirations make a 67 year old doctor want to make this situation even worse by taking on out of hours sessions in a different healthcare system in a strange country, where consultations must be conducted in an unfamiliar language? The tragic story of Daniel Ubani (*BMJ* 2010; 340:c3326, doi:10.1136/bmj.c3326), which culminated in the unlawful killing of David Gray in February 2008, is well known but still seems poorly understood. Dr Ubani was trained in Nigeria but is a German citizen and had apparently been working in Germany as a specialist in anti-ageing medicine and cosmetic surgery in the town of Witten. How exactly did he come to be admitted to the performers' list of Cornwall and Isles of Scilly Primary Care Trust in July 2007?

The free movement of workers is a founding principle of the European Union, and the current legal framework supporting this principle in relation to healthcare and other professionals is laid out in the somewhat gruelling 121 pages of Directive 2005/36/EC of the European parliament on the recognition of professional qualifications. Earlier versions of the directive had been criticised for prioritising the free movement of goods, services, people, and capital above the imperative of safety of patients, and the 2005 directive is much more balanced. However, it is the provisions of this directive that apparently allowed the events that led to the negligent killing of David Gray to unfold. The problems seem to be, firstly, that its provisions have not been used maximally within the NHS, perhaps because no one acted on the changes; and, secondly, that general practice is inappropriately handled within the directive.

Paragraph 3 of the preamble to the directive makes it clear that "the guarantee conferred by this Directive on persons having acquired their professional qualifications in a Member State to have access to the same profession and pursue it in another Member State with the same rights as nationals is without prejudice to compliance by the migrant professional with any non-discriminatory conditions of pursuit which might be laid down by the latter Member State, provided that these are objectively justified and proportionate." Safe and effective general practice, particularly out of hours, is intensely dependent on adequate understanding of the context of practice. Any doctor working in these circumstances needs to be familiar with the *British National Formulary* and with the local arrangements for accessing secondary care and emergency support. It follows that these could provide the basis of "objectively justified" conditions.

Article 3 of Title I of the directive allows an "aptitude test" "limited to the professional knowledge of the applicant to be made by the competent authorities of the host Member State with the aim of assessing the ability of the applicant to pursue a regulated profession in that Member State. In order to permit this test to be carried out, the competent authorities shall draw up a list of subjects which, on the basis of a comparison of the education and training required in the Member State and that received by the applicant, are not covered by the diploma or other evidence of formal qualifications possessed by the applicant." Again, anyone working in general practice within the NHS requires detailed knowledge of the working of the healthcare system, and this is certainly part of the education and training required in the United Kingdom.

Finally, under Title IV, Article 53, the directive states: "Persons benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State"—with the clear implication that such linguistic skill can be assessed by the competent authorities in the host country.

**"The UK has one of the best systems of specialty training for general practice in the world . . . yet this does not translate into specialty status at the European level, apparently because of a lack of political will on the part of successive UK governments"**

Perhaps even more fundamentally important than all of this is the continuing presence of a section within Annex V of the directive specifically for general practitioners (5.1.4), who are treated differently from "specialised doctors" (5.1.3). This seems to perpetuate the historically lower status of general practice, which is now completely inappropriate, given the highly skilled, high risk nature of primary care. It is well time that European general practitioners were treated as medical specialists in their own right, and this would allow more stringent qualifications to underpin safer free movement. Arguably, the UK has one of the best systems of specialty training for general practice in the world, with a lengthy and detailed curriculum and a demanding licensing examination on the completion of training. And yet this does not translate into specialty status at the European level, apparently because of a lack of political will on the part of successive UK governments and because the procedures laid down in Article 26 of the directive are tediously bureaucratic.

A recent position paper from the European Union of General Practitioners on the evaluation of Directive 2005/36/EC (www.europarl.europa.eu/document/activities/cont/201010/20101027ATT90659/20101027ATT90659EN.pdf) calls for general practice to be recognised as a specialty across Europe, quality criteria on training to be introduced rather than a simple time requirement, standards to be set for continuing medical education in general practice, and the language requirements for migrant doctors to be much more clearly defined.

Only when these are achieved will the lessons of the stories of David Gray and Daniel Ubani have been learnt.

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- Local government will review doctor struck off in UK, German medical association says (*BMJ* 2010;341:c4653)
- Locum GP from Germany is struck off medical register (*BMJ* 2010;340:c3326)
- Patient died after out of hours care firm ignored doctor's warnings (*BMJ* 2010;340:c3869)

ETHICS MAN **Daniel K Sokol**

# Of interviews and examination machines

## Incessant assessment at medical school risks the loss of the skills of reflection, deliberation, and communication among tomorrow's doctors

I was once paid a neat little sum to give a lecture. It was no keynote address to a distinguished audience in the Caribbean but a talk to 200 or so school leavers who were preparing for medical school interviews. Why an ethicist? Because it is not unusual for 20% of an admissions interview to be about ethics. A good answer displays maturity and nimbleness of thought and lifts the candidate above the rest. A poor one can signal the end of the road or, at best, an uphill struggle for the rest of the interview. Most candidates make an acceptable but unimpressive effort, usually far too one sided.

The ethics questions at admissions interview tend to be the old chestnuts. Do you think people should have the right to die? Should we allow people to sell their organs? Should parents be allowed to choose the sex of their baby? Generally it is not so much the candidate's position on an issue that matters as how he or she articulates and justifies that position. An answer suggesting that the issue is straightforward will not impress: "Definitely. Parents should be able to choose the sex of their baby." "Why?" "Because it's their choice, isn't it?" In my experience about 50% of candidates adopt this black and white approach. Good candidates will tease out the complexity of the issue, providing the most compelling reasons for various positions and explaining why they prefer one position over others.

These questions inject the fear of God into some students because they are difficult to prepare for. Therein lies their value. Candidates are often so rehearsed that without such questions the panel is none the wiser at the end of the interview. Still, it is possible to practise answering treacherous moral questions. You need, most of all, a willingness to see the various facets of the question and the ability to argue a position and, if asked, the opposite position.

What has this got to do with being a good doctor? Everything. Clarity of thought, awareness of the point of view of others (even if you disagree with it), and sound communication skills characterise the good doctor, alongside a firm grasp of medicine and sound clinical skills. Doctors in 2010 differ in many ways from their counterparts in 1910, but these qualities remain as relevant as ever. In the West the views of patients and relatives bear more weight today than they did a century ago, ethically and legally. In our large, multicultural cities the views are more diverse than in 1910, with a broader range of beliefs about life, death, health, and illness. Crucially patients now have a voice, and doctors must know how to listen to, evaluate, and respond to the views of patients, relatives, and even colleagues.

The skills of reflection, deliberation, and communication must be assessed at interview and instilled into the medical student, because they form part of the skill set of the well rounded doctor. There is, however, another reason why these skills must be taught: medical schools are still universities, and one of the fundamental purposes of a university is to teach students to think. Although pathology, anatomy, physiology, and other scientific disciplines are tremendously important, a medical degree should be more than learning about clinical medicine. As the poet Saint-John Perse wrote, "C'est de l'homme qu'il s'agit" (roughly, "The subject matter is man (humanity)").

The following has been said before but is worth repeating: there are too many assessments in medical school; too much learning by rote, not enough thinking. Every few weeks students sit yet another exam. Although I despair at students asking, "Will this be in the exam?" they are not to blame for becoming exam machines. They are merely playing the game. Occasional assessment may drive learning, but incessant assessment dulls the mind, suppresses curiosity, and stifles creativity. Students have little enough time to read, study, and explore "for pleasure" without the Damoclean sword of assessment dangling overhead.

> **"The intellectual well from which medical students draw their views and beliefs on the art and science of medicine is getting dangerously shallow. At this rate the cultivated doctor will soon be a thing of the past"**

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Medical students today are accustomed to multiple choice questions, short answers, and bullet points. There is little scope for originality. Examiners are often not permitted to mark down for consistently poor spelling or ungrammatical constructions. In some medical schools the old fashioned essay has virtually vanished, deemed too subjective by educationists. Although much emphasis is put on oral communication skills, written skills are overlooked, even though doctors have to write on a regular basis. Marking hundreds of exam scripts is a soul sapping experience, but for an examiner with an ounce of respect for language it can be exasperating. When the students eventually qualify as doctors they are under pressure to publish. It is no surprise that many find writing articles taxing. I wonder whether long serving editors of medical journals have seen a decline in the standard of English in submissions over the past few decades.

In 1925 the US reformer of medical education Abraham Flexner wrote that "scientific medicine in America—young, vigorous, and positivistic—is today sadly deficient in cultural and philosophic background." Eighty five years on the deficiency is greater still. Students and the new generation of doctors, the vast majority of whom are bright and talented, are let down by a system of medical education so obsessed with concrete, measurable outcomes that it transforms many of them into semiliterate examination machines. The intellectual well from which medical students draw their views and beliefs on the art and science of medicine is getting dangerously shallow. At this rate the cultivated doctor will soon be a thing of the past.

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MEDICINE AND THE MEDIA

# What next for public understanding of research?

It's a given that researchers must explain their work to taxpayers, writes **Geoff Watts**, 25 years after a Royal Society report recommended this. Taking the principle further, however, is controversial

"Don't write for the *New Scientist* before you get your fellowship of the Royal Society. If you do you won't get it at all." In an age of near incontinent communication about anything and everything it's difficult to recall that this antiquated piece of advice to junior scientists once had foundation. It reflected a view, widely held in the scientific and medical establishment, that talking to the media was not the thing to do. Discourse on such matters was best between professionals. One of the developments that helped sweep away this fusty, inward looking attitude was the Bodmer report of 1985.

The subject of a 25th anniversary seminar held at the London School of Economics last week, the geneticist Walter Bodmer's influential report on the public understanding of science was commissioned by the Royal Society (http://royalsociety.org/Public-Understanding-of-Science/). Its core message was to researchers: that they have what amounts to a duty to communicate with the public and to the Royal Society itself, which should, said Bodmer, encourage and facilitate this. Hence was born the faintly Orwellian sounding Committee for the Public Understanding of Science (CoPUS).

For journalists working in the pre-Bodmer era, circumstances were vastly different from those of today. I was part of a journalistic delegation that went to lobby the then secretary of the Medical Research Council. No names and no date—I've no intention of betraying confidences—but we met him in a club in Pall Mall and explained that, although the MRC funded a great deal of excellent research, very little effort was made to let anyone know about it. Could this be rectified? The man was charming and obliging and said that he thought that something could indeed be done. But he was also puzzled: why did we want to know about this research?

This jaw dropping question took us all by surprise. Was he really unaware of the public's interest in what scientists and doctors got up to in their laboratories? Apparently yes. What effect our little delegation had I can't say. But, along with the much heavier pressure applied by the Bodmer report and other calls for change, the earth moved. The trickle of press information has since become a deluge.

**Walter Bodmer: influential report**

Speaking at the LSE seminar, the former *Guardian* journalist Tim Radford reflected on the quite extraordinary public ignorance about science that he encountered when, long ago, he made his abrupt career change from the arts pages to the science beat. Quoting the title of a paper chosen at random from *Nature* he also remarked that even when researchers had begun to appreciate the need to communicate they were hampered by the inherent complexities of their subject and of the language used to discuss it.

**What researchers plan to do next should also be subject to public scrutiny, discussion, and—still a sticking point for many scientists—sanction**

The sociologist Hilary Rose reminded her audience that limited efforts at fostering a wider understanding of science had begun long before Bodmer. Nineteenth century engineers and scientists, for example, would sometimes share their knowledge of the natural world in public lectures, often to a predominantly working class audience. The British Association for the Advancement of Science (forerunner of today's British Science Association) took up the cause, serving the needs of a rather different audience.

Also at the seminar was a past executive secretary of the British Science Association, Peter Briggs. As the man who ran CoPUS in its early days he was well placed to know how often it had attracted criticism. But some of its innovations continued and thrived. He mentioned the fellowship scheme through which, every year, a dozen scientists get the chance to spend a few weeks working in print or broadcasting and then—so it's hoped—go back to their laboratories and spread the word that dealing with the media can be a rewarding and even pleasurable experience.

The final speaker, Mark Dyball of the People, Science, and Policy consultancy group, chose a handful of quotations on science and society from the Bodmer report, put them beside others from more recent documents, and then challenged his audience to identify which were which. The task was not easy; so how much had really changed, he wondered? His own view was that change had occurred, but he cautioned against exaggeration.

The concept of public understanding began to fall from grace when critics pointed out that dispensing pearls of scientific insight to a grateful public was not enough. Science is a social enterprise, much of it funded by the state. Scientists, besides telling everyone what they're about, should also be listening to the public. Hence the newer notions of dialogue and public engagement in science—of two way communication.

An even more recent development is "upstream engagement." This catchy little term, which has yet to make much impact outside science policy circles, questions the assumption that attention should be focused only on what scientists are doing now. The upstream bit is to suggest that what researchers plan to do next should also be subject to public scrutiny, discussion, and—still a sticking point for many scientists—sanction. Public engagement is now firmly on the agenda; its upstream extension is still a work in progress.

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**Danny Alexander, George Osborne, and Vince Cable are all on the Demos advisory council**

LOBBY WATCH **Jane Cassidy**

# Demos

**Who are they?**

However much it tries to move on, Demos will be forever linked to the Labour boom years. It was credited with helping to shape the concepts of New Labour and Cool Britannia, and Tony Blair was at its launch. It was founded by the academic Geoff Mulgan and the *Marxism Today* editor Martin Jacques in 1993. Mulgan got a job at Number 10 when Labour swept to power in 1997.

**What do they do?**

Recently Demos has been involved in two high profile projects examining death related issues. On 30 November Demos headquarters in London hosted the launch of the Commission on Assisted Dying, chaired by the former lord chancellor Charles Falconer (*BMJ* 2010;341:c6622). The commission is calling for evidence to consider whether a system should exist to allow people to be assisted to die and whether any change in the law was needed. The consultation will run until September 2011, and a report will follow in October.

The campaign group Dignity in Dying helped set up the commission, with funding from Bernard Lewis, the founder of the River Island fashion chain, and the author Terry Pratchett. Demos is providing administrative and research support. The commission will act entirely independently from the support organisations and financial backers. Its conclusions will be formed on the evidence received, says the think tank.

Dying for Change, a Demos pamphlet funded by Help the Hospices, came out in mid-November (*BMJ* 2010;341:c6508). It says that few people get their wish to die at home rather than in hospital and estimates that an investment of £500m (€590m; $800m) a year would fund community services, allowing 50% of people to die at (or in places close to) home.

**What agenda do they have?**

Demos seeks to influence policy making by focusing on issues involving family and society; violence and extremism; the public interest; political economy; public finance; and political ideas on both left and right. Its mission, it says, is to challenge the traditional "ivory tower" model of policy making by giving a voice to people and communities and involving them closely in its research.

**What does the government think of them?**

The former Labour MP and economist Kitty Ussher is now the director of Demos, and the former health secretary Alan Milburn and Labour MP Jon Cruddas are advisers. However, Demos has moved to forge links with the coalition government. Its last director, Richard Reeves, left to become Nick Clegg's special adviser just after the last election.

The coalition government's business secretary, Vince Cable, and his fellow Liberal Democrat MPs David Laws and the chief secretary to the Treasury, Danny Alexander, are all on the think tank's advisory council. Joining them are the Tories George Osborne, chancellor of the exchequer, and David Willetts, the minister for universities and science.

Julian le Grand, chairman of Health England and a social policy professor at the London School of Economics, is also an adviser.

**How influential are they?**

The early association of Demos with New Labour is likely to remain in the minds of the present government, limiting its influence among some ministers.

**Where do they get their money from?**

Funding is not accepted from political parties. Backers are diverse, ranging from big business names, including Pfizer, to charities such as the Multiple Sclerosis Society.

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FROM BMJ.COM

## Five a day and two a night

Kirsten Patrick is delighted about a new initiative to enthuse youngsters to exercise. "Yesterday my six year old son demonstrated to me one of the daily workouts that he and his classmates do between lessons at school," she writes. "They use a programme called five a day fitness. The class follows five minutes of dance or fitness moves demonstrated by an 'instructor' projected up on to the white board via a laptop. My son's favourite is 'workout,' a pretty complex sequence of dance moves, crossover steps, twirls, star jumps, and wiggles. Almost as good, he says, is 'disco.' There's also 'robot,' 'hula,' and 'march,' and a trio of chill out options, 'stretch,' 'balance,' and 'breathe' . . . The kids just do it in their school clothes on the carpet in the classroom. No need for changing, no need for special props; just gravity and their bodies. They're being reminded daily that they have bodies appended to their brains. This can only be a good thing."

Julian Sheather thinks that a glass of wine, or two, is conducive to reflecting about life, and finds himself confronted with an interesting dilemma: "Over lunch recently a friend asked me what I thought were the moral harms of addiction. What was it about addiction, rather than the more regular satisfaction of ordinary appetites, that attracted a particularly moral unease?" he asks. "There is of course an extensive literature on the harms of the substances most liable to abuse. Physical harms; harms to health. The social costs are also high. Direct costs to the health service, less definable harms to the social fabric. No dispute here, on the whole, but not quite what we had in mind. To take only my life and the lives of those close to me, what is the nature of that fear, that bogey, that haunts us steady mid-life topers? Numberless, reader, are the times I have heard a friend, wine in hand, wonder whether his or her glass or two a night amounts to addiction. So what, I wonder, is going on?"

Richard Smith hopes that next year's UN meeting will shine a spotlight on chronic disease, a topic hitherto shrouded in obscurity. "It might surprise you that chronic disease is such a major threat to the global economy," he writes. "One of the big problems for 'those of us concerned about chronic disease' is what to call it. What we mean is 'cardiovascular disease, diabetes, chronic obstructive pulmonary disease, and the common cancers'—not the many other diseases that doctors know to be chronic, including not only neurological, rheumatological, and psychiatric conditions but also, of course, AIDS and tuberculosis. We've adopted the narrow definition because these problems account for 60% of global deaths and are largely caused by the same risk factors—tobacco, poor diet, physical inactivity, and alcohol."

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