

'... the idea was to prove at every foot of the way up that pyramid that you were one of the elected and anointed ones who had the right stuff and could move higher and higher ...'

Tom Wolfe, in *The Right Stuff* (1979)

Almost every patient in the UK is affected by the capacity of the medical work force to contribute to the delivery of primary care, and by the personal qualities, skills, and training of the GPs who make up that workforce. Little wonder then that the general practice workforce features high on the political agenda.

In terms of workforce capacity, concerns are mounting in view of the demographics that predict unfilled retirement vacancies.¹ The target set by the Department of Health that 50% of new medical graduates should be recruited to general practice each year^{2,3} is still recognised as important, but is proving difficult to achieve when the percentages of recent graduates naming general practice as their first choice remains constant at little over 20%.⁴ Health Education England (HEE) have reported only an increase of 95 recruits to GP training this year, and they have demanding targets to meet in terms of increasing numbers in training as well as enhancing training.⁵ Although the government's mandate to HEE endorses extending GP training to 4 years, this has not yet become part of the business plan. With quantity and quality of recruits a matter of considerable public and professional concern, it is worth unpicking four issues which impact on the quality of the patient experience.

Firstly there is the question of whether the 'right' people choose medicine as a career, and do the 'right' medical graduates choose general practice? Secondly, which of the aspirant students and doctors should the medical schools and postgraduate training schools select for training?

Thirdly, as 'the anointed ones' complete stages in their training, how fairly and effectively are the judgements made on their competence and suitability? Finally, how well do these choices and judgements stack up in terms of how the chosen ones perform in their careers? There are two significant articles in this issue which contribute to our knowledge on the second⁶ and third⁷ of these issues.

INFLUENCING CHOICE AND ENHANCING RECRUITMENT

Addressing the failure to recruit more newly-qualified doctors into GP specialist training requires a number of approaches. The parallel emphasis by HEE on supply and demand⁵ is intended to presage engineering whereby local education and training boards (LETBs) ensure that there is more capacity in terms of training placements for GP trainees, and this means reducing specialist training numbers. Career guidance has been recognised as an important and overlooked factor, and common sense (if not evidence) would suggest that professional morale and professional image are important if undergraduate and foundation placements in practice are to encourage rather than discourage recruitment. Medical schools can do more to encourage that students are positively orientated to general practice, something which newer medical schools appear to do better than some of the more established ones and high quality careers advice is often overlooked.⁸

THE NATIONAL SYSTEM FOR SELECTION FOR GP TRAINING

The collective effort on the part of the UK deaneries to address the lack of standardisation resulted in a national system for selection with machine marked components including situational judgement tests and clinical problem solving tests which contribute to shortlisting. The final stage involves attendance at a selection centre where situations pertinent to practice are simulated. Candidate reactions to this form of testing have been favourable.⁹ By showing in this issue⁶ that predictive validity of the MRCGP shortlisting tests extended up to the end of training, and that the use of the selection centre offered incremental improvement, Patterson and colleagues have laid the

foundations for research to test the impact of these new skills on real patients in practice. It is a pointer to the success of this selection system that it is now to be piloted in specialties outwith general practice.¹⁰

DEBATES AROUND THE MRCGP CLINICAL SKILLS ASSESSMENT

Just as it seemed that slowly, slowly we are getting some partial answers to important questions, we have been brought up short by the realisation that more information does not mean more consensus. Even as the eagerly awaited information emerged on the MRCGP clinical skills assessment (CSA), the divergent interpretations (by the same authors) of data on assessment performance in this cornerstone test of GP competence^{11,12} has excited much soul-searching inside and outside the Royal College of General Practitioners.

The contribution in this journal by Denney and colleagues⁷ is a welcome addition to the debate. On the one hand a similar level of paradox is reported as was evident in the reports of Esmail and Roberts.^{11,12} Those who wish to engage with this complex topic have to be prepared to move from univariate to multivariate analysis. On the other hand, Denney *et al* were able to reach a point where they were confident enough to report that 'examiners show no general tendency to favour their own kind.'

We are left in an uncomfortable position: if bias is not the explanation for such a strong disparity in assessment outcomes, then is the reason for this disparity desirable or undesirable in educational terms? Clearly it is undesirable that so many diligent and talented black and minority ethnic doctors from non-UK backgrounds are encountering heart-rending difficulties with this compulsory hurdle to accreditation. Their experience is disproportionate to the experience of white and UK-trained colleagues. But

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"It is becoming more possible to look for improvements in patient care that relate to all stages in the process of primary care workforce development."

is the assessment the problem or is it the training for and the approach to the assessment that merits our most stringent attention? It is desirable in educational terms to have assessments that detect doctor performance which, if undetected, would have an adverse impact on patient experience. I don't think we are, yet, in a position to be sure, and until we are, from an educational point of view, we should not rush to set aside such a well-researched and well-developed assessment as the CSA. The rapid responses to Esmail and Roberts' *BMJ* article¹¹ illustrate that this assessment is delivered by many caring, fair-minded, and highly-trained examiners. For now, we have nothing better to replace the test, which is not to say that it should be immune to rigorous further development.

THE OUTCOMES THAT MATTER

The literature is sparse on how our best attempts to recruit, select, train, and assess GPs measure up in terms of beneficial impact on the patient experience, and we need to look to proxy measures. The postgraduate assessments in other specialities are one such measure, and McManus and colleagues report exciting work on physician training,¹³ whereby they developed the theoretical basis for a concept of the 'academic backbone'. The evidence that earlier attainment at secondary school, and in undergraduate

and in postgraduate training predict performance up to and including entrance to the specialist register is a demonstration of what can be shown using sophisticated analysis of large cohort data. This group conceive that performance in assessment is achieved by the development of structured and applied knowledge. This 'cognitive capital' or 'medical capital' now needs to be related to doctors' performance in the care of patients.

CONCLUSION

With a hefty research agenda ahead, those who are interested in GP education can now get to work in teasing out ways to relate process to outcome in respect of recruitment and career advice; selection into medical school and onto postgraduate training schemes; and assessments in postgraduate training. It is becoming more possible to look for improvements in patient care that relate to all stages in the process of primary care workforce development.

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Is UK general practice education and training now fit for purpose?

INCREASING JOB DEMANDS FOR GPs

Recent major structural and policy developments in the UK health services have significantly impacted on the primary role of the GP as a generalist clinician; there is increasing emphasis on their capabilities as team leaders, care coordinators, educators, and commissioners.¹ Sir Bruce Keogh, the NHS Medical Director in England, is exploring issues of demand for services and the need to ensure people with long-term conditions are better looked after outside the hospital system, thus reducing their need for emergency care services. The Health Secretary for England, Jeremy Hunt, is calling for better integration between the health and social care systems, which implies a significantly revised model for the delivery of primary care. NHS England launched 'Call to Action'² to stimulate debate in communities and enable GPs to play a stronger role in delivery of out-of-hospital integrated services for an improved patient experience, personalised care, with more effective and efficient use of the resources. In the devolved administrations there are similar policy directives reflecting the wish to increase care in the community in the future.³⁻⁵ Consequently, there are significantly increasing job demands, not least from patients, for GPs to be better prepared to manage increasingly complex long-term conditions. To what extent do the current curriculum, the training provision, and the licensure assessments accommodate these changes?

EVIDENCE FOR NEW COMPETENCIES REQUIRED IN A BROADER GP JOB ROLE

New evidence from a multi-source, multi-method job analysis study⁶ (involving interviews, focus groups, observations of GPs at work, a survey; $n = >1400$) identifies a framework of eleven competency domains including:

- Empathy and perspective-taking
- Communications skills
- Clinical expertise
- Conceptual thinking and problem-solving
- Organisation and management of resources
- Professional integrity
- Coping with pressure
- Effective teamworking

- Respect for diversity and the law
- Learning and development of self and others
- Leading for continuing improvement.

GPs are required to consider how their work impacts on communities: both to address the health of the population they serve, and how this is managed within the wider health service, with new competencies now required (such as Leading for continuing improvement) compared to an original job analysis conducted over 10 years ago.⁷

Research evidence is sparse regarding the skills and attributes required by community generalists to be effective as their role expands outside of the consulting room, especially relating to planning services for population-based healthcare and proactive preventative care for those at risk.⁶

IMPLICATIONS FOR WORK DESIGN AND TRAINING VALIDITY

Research evidence highlights three core themes arising that have significant implications for work design in general practice, including increased role breadth, increased potential for role conflict, and concerns around the level of preparedness for practice after training.⁶

Regarding an increased role breadth, results show an enhanced emphasis for GPs to consider multiple agendas beyond the patient and their practice in future. GPs are required to focus on balancing individual (local) needs versus their registered population's health (such as 'bigger-picture' thinking), and to take on multiple complex roles in future. However, there is increased potential for conflict in relation to ethical values. GPs are required to demonstrate commitment to patient care and maintain patient trust,

which may at times conflict with managing limited resources. Increasingly, GPs need to resolve these significant competing tensions to be effective in their role. For individuals, there is a potential ethical conflict between these tensions, which may be at odds with their identity as a clinician. Research in work design implies this will increase the risks of experiencing work-related stress, reduced job satisfaction, and burnout.⁸ With competing job demands for individuals, to remain effective, trainees will require specific support to deal with these conflicts and significant changes in work design.

There are identified concerns regarding the level of trainee preparedness for practice given these new job demands. For example, there are gaps in training provision relating to dealing with challenging psychosocial issues and complex long-term health conditions facing patients. Several new domains relate to an increasingly broad range of non-clinical activities such as leading for innovation, business acumen, adopting collaborative approaches when working in expanded multiprofessional teams⁶ (in addition to managing healthcare pathways effectively), which are not currently assessed in training or tested directly by the current MRCGP licensure exams.

To what extent do trainees feel confident that they are able to carry out a broader and more proactive role? Self-efficacy is an important motivational dimension to consider in future education and training activities as it influences individual goals, emotional reactions, effort, coping, and wellbeing.

This proposition is consistent with survey data from recently qualified GPs now reporting significantly higher levels of stress than their counterparts,⁹ and with evidence showing a significantly increased number of GPs intending to quit.¹⁰ There

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is also a risk that perceived stress in the profession will affect recruitment in future; at a time when the number of GPs needs to expand.

THE CASE FOR TRAINING TO BE RECONFIGURED?

Given the extensive range of responsibilities and capabilities required, this work supports the case for enhancement of the current training provision to ensure it reflects the role changes and the greater breadth of competencies now needed by GPs. To ensure validity, further work is required to define the optimal content and construction of training to support the career pathway (and, by extension, patient care) appropriately in future.

The educational value of reconfiguring GP training by the RCGP to encompass these and other new domains has been widely recognised by health departments. Inevitably, there will be differences in the role of GPs in the health systems across the UK, but it is essential that there is a single set of national training standards that are fit for purpose.

Much of the training should now take place in posts that provide services in community settings, with a focus on GPs leading the response to population health issues, developing generalist competencies and working collaboratively in multiprofessional teams to develop expertise together to tackle the increasing complex profile of patients with long-term conditions. Such posts should play a key role in facilitating the shift of patient care into the community, supporting new models of emergency care, and contributing to the development of in- and out-of-hours services.¹¹ Flexibility in the nature of these posts at a local level is important to ensure the provision of the highest quality training environments,

and provide for a cost-effective method of delivery. All programmes will need to follow a well-defined curriculum setting out new competencies that can be acquired in a wide variety of training environments; service delivery should be an important component, as will working in multiprofessional teams, supported by high quality mentoring and support systems for future GP trainees.

Given that the first cohort of trainees recruited into new educationally approved extended programmes are unlikely to reach the start of their fourth year until 2018, there is time to plan the essential changes in service delivery and to revise aspects of the curriculum, while also providing the new community-based training posts in a cost-effective manner. The result will be a better trained, confident, and capable GP workforce, educated in an environment that delivers new models of high quality patient care. By ensuring that the education and training provided is fit for purpose, newly-qualified GPs will be fit for practice, in an increasingly challenging workplace.

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Fitness for work:

changes in sickness absence management

RADICAL CHANGES IN SICKNESS ABSENCE MANAGEMENT

The government's response¹ in January this year to the Sickness Absence Review by Dame Carol Black and David Frost,² which was published in November 2011, will radically change the way sickness absence will be managed in future. In Great Britain, from 2014, an independent, State-funded Health and Work Assessment and Advisory Service will see those who have been off work for 4 weeks and provide assessment, advice to employees, employers, and GPs, signposting to interventions, case management, and follow-up.

GPs' ROLE IN FITNESS FOR WORK

Most GPs will welcome these changes. Previous research³ has already shown that GPs support the idea of an independent assessment service and would be happy to engage with one. Currently, many GPs, employees, and employers struggle to access necessary and appropriate expert advice that can improve sickness absence management. The new Service will produce reports for all three parties.

In recent years, GPs have become increasingly aware of the strong evidence of the positive benefits for physical and mental health and wellbeing of good work and the damage caused by unemployment and prolonged sickness absence.⁴⁻⁸ Many have attended the Royal College of General Practitioners' national education programme about health and work,⁹ which is designed to increase GPs' knowledge, skills, confidence, and effectiveness in dealing with clinical issues relating to work and health. Many too have made use of the Healthy Working UK website (<http://www.healthyworkinguk.co.uk/>), which provides doctors and other healthcare professionals access to information, guidance, and training on the management of health and work. Guidance on the fit note, for GPs, employers, and employees, has been published;¹⁰ the GP guide is intended to help family doctors make best use of the fit note to support their patients.

Most GPs are only too aware that the longer someone is off sick or out of work, the harder it is to get back to work. Worklessness comes at great personal, financial, and social cost, not only impairing individuals' health but leading to loss of

worth and self-confidence, poorer social integration, poverty, and damage to families and their health and wellbeing.^{4,6}

A FIT FOR WORK SERVICE

It is good news that the government response¹ goes beyond the recommendation of the Sickness Absence Review² that there should be an assessment and advisory service, and recognises the importance of intervention, case management, and follow-up. However, the response is as yet somewhat vague about how the necessary interventions will be funded and delivered. GPs are often frustrated about delays in access to NHS services such as physiotherapy and cognitive behavioural therapy that their patients need. Without timely intervention, unnecessarily prolonged sickness absence and long-term worklessness can result. It is essential that there are further discussions with interested parties, including the representatives of GPs, about how to ensure the right interventions are delivered at the right time. That includes placing obligations on employers to implement the Service's recommendations on workplace adjustments whenever possible.

The government response is also vague about how GPs will refer patients to the new Service. While the report implies that the fit note itself will trigger referrals, at a time of rising GP workload, GPs will want the referral system to be simple and streamlined, without requirements for detailed referral letters or questioning of patients about their employers' occupational health arrangements. Although the responsibility for issuing any subsequent fit notes will not always rest with GPs, there needs to be clarity about where responsibility lies.

The new Service is to be staffed by 300–740 occupational health professionals and 5–10 physicians specialising in occupational health or vocational rehabilitation. Additionally, it is estimated that the

Service will generate demand for 240–1300 healthcare professionals to provide interventions.¹ Given that occupational health professionals are already in short supply and many are towards the end of their careers, it is important that the new Service can find the workforce it needs without detriment to other occupational health provision. One uncertainty is whether and how the Fit for Work Service pilots⁶ may migrate into the new Service.

SERVICE QUALITY AND BENEFITS

The quality and standards of the Service must be monitored to ensure it is delivering the necessary benefits. Another work-focused government-implemented assessment, the Work Capability Assessment,¹¹ has caused widespread concern. Professor Harrington's independent reviews of the implementation of the Work Capability Assessment demonstrate the importance of assessments being fit for purpose. It is imperative that the new Service is quality-controlled and that its assessments are fair, valid, effective and trusted.

The economic modelling in the government report is inevitably hypothetical, but suggests that the Assessment and Advisory Service will generate net benefits in terms of increased tax and National Insurance revenues, reduced expenditure on benefits and sickness absence payments, and increased economic output. It is predicted that the Service will cost £20–£85 million per year, but will generate yearly net benefits to employers of £65–£80 million and to government of £105–£225 million, and will increase economic output by £450–£900 million annually. These figures need to be considered against the background of the current costs of sickness absence: £15 billion to the economy, £9 billion to employers, £4 billion to individuals, and £2 billion to the government. The economic modelling assumes that the Service will

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reduce average sickness absence duration by 20–40%. (Given that the median duration of sickness absence for those reaching the 4-week point is 42 working days, such a reduction would yield 8 to 17 extra working days on average.)¹ While the report rejects the Black–Frost recommendation of tax relief on medical treatment or vocational rehabilitation, the government intends to retain tax relief on Employee Assistance Programmes and announced in the 2013 budget that it would introduce tax relief on interventions recommended by the Assessment and Advisory Service.¹²

THE NEED FOR BETTER DATA

The report emphasises the importance of data in monitoring progress. Analysis of information from the rollout of electronic fit notes and from the new Assessment and Advisory Service will help, as will monitoring progress on the Health, Work and Wellbeing initiative using such indicators as reducing the proportion of people out of work due to ill-health and improving access to appropriate and timely health service support.¹³ However, more needs to be done, in terms of mainstreaming employment through all relevant health policy frameworks; collecting data on employment outcomes; and, in England, incentivising attitudinal change and data collection through the Commissioning Outcomes Framework. Whether patients stay in or return to work is an important indicator of clinical success.^{1,7,8}

CONCLUSION

In summary, the government response will have a major impact on how sickness absence is managed in Great Britain, in particular through the introduction of the new Assessment and Advisory Service next year. However, there are still some issues to be resolved in respect of referrals, interventions, workforce, quality monitoring, and data collection. GPs and other stakeholders will be keen to work with the Department for Work and Pensions to ensure the new processes not only lead to cultural change but produce benefits for employers, taxpayers, the economy, health

care professionals and most importantly for the future of those employees and patients at risk of long-term worklessness.

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Future Hospital Commission:

the time for action

Our hospitals are struggling to cope with the challenges of an ageing population, increasing hospital admissions, and a failure to provide coordinated, patient-centred care; added to a looming crisis in the medical workforce, and the need to find £20 billion efficiency savings by 2015. It is clear that radical steps need to be taken if we are to be able to provide high quality medical care.

In March 2012 the Royal College of Physicians established an independent Future Hospital Commission with the aim of addressing these challenges. The Commission, chaired by Sir Michael Rawlins, brought together patients and healthcare experts from many disciplines including general practice, to build a vision of what comprehensive high quality medical care for patients could look like. Its report *Future Hospital: Caring for Medical Patients*,¹ published on 12 September, sets out the Commission's vision for hospital services structured around the needs of patients, now and in the future. It focuses not only on the care of acutely ill medical patients, but also the organisation of general and elective medical services, and the role of physicians and doctors in training across the medical specialties in England and Wales. People's needs are often complex, and hospital services must be organised to respond to all aspects of physical health (including multiple acute and chronic conditions), mental health and wellbeing, and social and support needs. Importantly, the Commission decided its recommendations must be cost neutral, bearing in mind the need for financial stringency.

PRINCIPLES OF PATIENT CARE

The report envisions principles of patient care that place as much value on the experience and compassion as clinical effectiveness. They major on dignity, compassion, confidentiality, and privacy, food and nutrition, responsibility for care including a named consultant, transfer arrangements and care plans. Together, they underpin all the other recommendations in the report.

CREATING THE FUTURE HOSPITAL

The Commission also sets out a radical new model of care designed to encourage collective responsibility for the care of patients across professions and healthcare teams. It recommends new ways of

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working between hospital and community, supported by financial and management arrangements that give greater priority to caring for patients with urgent medical needs. This will mean aligning financial streams and incentives, both externally and internally, to ensure that acute services are appropriately supported, and set within a comprehensive healthcare system. Thus, care should come to patients and be coordinated around their medical and support needs, wherever they are, obviating the tendency for patients, particularly older people, to move beds several times during a single hospital stay. This is known to result in poor care, impaired patient experience and to increase length of stay. In the future hospital, moves between beds and wards will be minimised and only happen when necessary for clinical care. Delivery of specialist medical care, such as cardiology and neurology services, will not be limited to patients in specialist wards or to those who present at hospital. Specialist medical teams will work across the system 7 days a week.

The design and delivery of services will also consider the specific needs of older patients with cognitive impairment, and those known to have poor levels of access and outcomes, for example, those with mental health conditions and or who are homeless. To coordinate care, the Commission recommends that each hospital establish the following new structures.

Medical Division

The Medical Division will be responsible for all medical services across the hospital; from the emergency department and acute and intensive care beds, through to general and specialist (including surgical) wards. Medical teams across the Division will work together to meet the needs of patients, and coordinate care, including for those with complex conditions and multiple comorbidities. The Division will work closely with partners in primary, community, and social care services to deliver specialist medical services across the health economy.

Acute Care Hub

The Acute Care Hub will bring together the clinical areas of the Medical Division that focus on the initial assessment and stabilisation of acutely ill medical patients. These include the acute medical unit, ambulatory care centre, short-stay beds, intensive care unit and, depending on local circumstances, the emergency department. The Acute Care Hub will focus on patients likely to stay in hospital for less than 48 hours, and patients in need of enhanced, high dependency, or intensive care. An acute care coordinator will provide operational oversight to the Acute Care Hub, supported by a Clinical Coordination Centre, liaising with the community-based parts of the system as needed.

Clinical Coordination Centre

The Clinical Coordination Centre will be

"Care for patients with multiple conditions will be coordinated by a single named consultant, with input from a range of specialist teams when their clinical needs require it."

the operational command centre for the hospital site and Medical Division, including medical teams working into the community. It will provide healthcare staff with the information they need to care for patients effectively. It will hold detailed, real-time information on patients' care needs and clinical status, and coordinate staff and services so that they can be met. In the longer-term, this would evolve to include information from primary and community care, mental health, and social care. This information would be held in a single electronic patient record, developed to common standards.

SEVEN-DAY CARE, DELIVERED WHERE PATIENTS NEED IT

We must bring the advances in medical care to all patients, whenever they need it, whatever their additional needs and wherever they are in hospital or the community. This means specialist medical teams will work, not only in specialist wards, but across the hospital. Care for patients with multiple conditions will be coordinated by a single named consultant, with input from a range of specialist teams when their clinical needs require it. The remit and capacity of medical teams will extend to adult inpatients with medical problems across the hospital, including those on 'non-medical' wards (such as surgical patients).

Once admitted to hospital, patients will not move beds unless their clinical needs demand it. They will receive a single initial assessment and ongoing care by a single team. In order to achieve this, care will be organised so that patients are reviewed by a senior doctor as soon as possible after arriving at hospital. Specialist medical teams will work together with emergency and acute medicine consultants to diagnose patients swiftly, allow them to leave hospital if they do not need to be admitted, and plan the most appropriate care pathway if they do. Patients whose needs would best be met on a specialist ward will be identified swiftly so that they can be 'fast-tracked'; in some cases directly from the community, bypassing accident and emergency.

For many patients with chronic conditions, acute exacerbations are common. Ongoing monitoring and care provided by primary care and specialist medical teams seek to reduce the frequency and acuity of these acute exacerbations. For these patients, the Medical Division of the future hospital will need to facilitate community access to the specialist teams to support patient-centred management. Therefore the

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specialties will support, 7 days a week, community services for home-based or self-management of chronic conditions, rapid access 'hot' clinics or 'frailty' units for immediate investigation and review, including exclusion of conditions, fast track pathways for proven intervention and aftercare services, and in-reach services to all medical wards including the Acute Care Hub for agreed pathways. The concept of discharge will therefore go: patients will be cared for in different parts of the integrated healthcare system.

We know it will be difficult to deliver such radical change, and the way hospitals implement the proposals will depend on local circumstances, size and staffing. However, we must show leadership in redeveloping services without boundaries across primary, secondary and community care, to deliver the seamless high quality medical care that our patients deserve.

Tim Evans,

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Provenance

Commissioned; not externally peer reviewed.

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1. Future Hospital Commission. *Future hospital: caring for medical patients. A report from the Future Hospital Commission to the Royal College of Physicians*. London: Royal College of Physicians, 2013.