EDITORIALS

The Medical Colleges: issues at the turn of the century

FOR MOST OF THE 20TH CENTURY, Australia's Medical Colleges have played an important role in our healthcare system. The Colleges were founded to maintain and enhance professional standards in medicine's various disciplines. This was achieved through providing opportunities for the continuing medical education of College Fellows, by certifying that aspiring specialists could practise independently, and by encouraging research. The training role of Colleges was progressively developed, with evolution of training curricula, and through involvement in selection of trainees, appointment of supervisors and accreditation of hospitals and other healthcare providers as suitable sites for specialist training.

Over the years, the Colleges have attained considerable professional and community respect. This respect has underpinned the freedom that Colleges enjoy and allowed for their participation in the medical profession's regime of self-regulation. However, this respect and standing could rapidly diminish if the Colleges do not jealously guard their independence, while acknowledging their accountability to society. In this, they should be concerned primarily with the knowledge, competence and performance of their Fellows and with ways to assist in the maintenance of these attributes.

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More recently, Colleges have sought to have the expertise of their Fellows contribute to community debates on the safety and quality of healthcare and broader health policy issues. This has been facilitated, in a number of instances, by the establishment of health policy units such as that of the Royal Australasian College of Physicians, which provides an evidence base for College views. For this expertise to be widely accepted, the Colleges must not be subject to external influences, nor have a major role in protecting their Fellows' financial and narrow professional interests.

Our Colleges increasingly recognise that they must be actively involved with the community and other key organisations in the healthcare and educational systems and that their activities should be open to external scrutiny. The acceptance of this move to external scrutiny is demonstrated by the strong support of the Colleges for the Australian Medical Council (AMC) to become the accrediting body for specialist education and professional development programs. Already, trial accreditation of two Colleges (the Royal Australian and New Zealand College of Radiologists and the Royal Australasian College of Surgeons) has demonstrated the rigour and value of the process.[1,2] Areas requiring improvement have been identified and the Colleges taking part have to report to the AMC on a regular basis on how these shortcomings are being addressed. Accreditation is helping the Colleges to ensure that they are meeting the expectations of their Fellows, trainees, providers of healthcare and consumers, and that they are publicly accountable. Hopefully, it will ensure that College trainees are not only skilled clinicians but also appreciate the issues associated with the delivery of safe, high-quality care in the Australian healthcare system. AMC accreditation is also providing a transparent pathway for other organisations to seek accreditation for training and professional development programs in competition with those of existing Colleges. No other country has developed such a robust external system of accreditation of specialist education and training, and the process is attracting considerable international interest.

Our Colleges are also working closely with the AMC and Medical Boards to establish specialist medical registers in all States and Territories. Among other benefits, these registers will allow the community to more readily identify medical practitioners as recognised specialists. As part of this process, Colleges are contributing to the development of the criteria for regular re-registration and examining how these can reflect the maintenance of professional standards.

Rightly, the community expects that all medical practitioners will maintain their competence and behave in a professionally appropriate way. While it may seem appropriate for Colleges to consider complaints that one of their Fellows has failed to meet these standards, Colleges in Australia do not have this role. Medical Boards, but not Colleges, have the statutory authority to investigate complaints against doctors and can give protection to the complainant. The legal position of Colleges in undertaking such investigations is far from certain. The appropriate role of the Colleges in such difficult matters should be to provide independent advice on standards to Medical Boards and other statutory bodies, and to provide assistance to the Board in the re-education and retraining of underperforming Fellows.

The traditional discipline base of the Colleges may impede innovative developments in healthcare delivery. Increasingly, there is overlap and close collaboration in clinical activities (such as in radiation oncology and medical oncology) and there is a trend to bring together, in one service unit, physicians and surgeons dealing with the same body system.

Strengthening the intercollegiate body (the Committee of Presidents of Medical Colleges), while maintaining individual College autonomy, may well assist this process by promoting multiple College training and professional development programs. This would seem preferable to formation of new Colleges, although the AMC now has a more robust and transparent process for these to be recognised.

If Colleges are to continue to command the respect and confidence of the medical profession and society, they must not become financially or otherwise dependent on government or other organisations with a vested interest in their opinions and contributions to public debate. While it is

understandable that Colleges, because of their unique expertise, may undertake some contractual work for governments or other organisations to assist in improvements to healthcare, this must be done with great caution. Colleges should ensure they are not influenced by the provider of the funds; furthermore, it would be extremely unwise to build up a significant College bureaucracy or facilities that are dependent on such external funding.

Equally, Colleges should be extremely reluctant to become fundholders for government-sponsored training programs or to build up organisations dependent on such funding. Political decisions, as has recently happened with the training program for general practitioners, can place a College in a very difficult position. The threat of removal of such funding and the resulting impact on the financial viability of a College could temper criticism of the policies of government or other organisations.

These issues have received considerable attention in North America and Europe. Pellegrino and Relman[3] recently argued strongly that a professional organisation such as a Medical College can not become involved in protecting its members' financial welfare or other narrow professional interests: "It would be far better . . . for physicians to promote patients' interests on ethical and medical grounds as members of medical associations than to seek confrontation as union members. In our view, unions and truly professional associations are simply incompatible." These sentiments obviously have parallels in Australia.

As the eminent ethicist Sullivan[4] points out, true professionalism depends on the moral contract between the professional and society. It is only when the responsibility to patients and to the public interest is held to be paramount that members of the medical profession can expect society to accept self-regulation of the profession and to listen carefully to proffered opinions and advice. Colleges must continue to promote these principles to their Fellows and trainees, and Colleges and their Fellows must demonstrate to society their commitment to them.

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2. Australian Medical Council. Accreditation Review of the Royal Australasian College of Surgeons. Canberra: AMC, 2001.
3. Pellegrino ED, Relman AS. Professional medical associations: ethical and practical guidelines. *JAMA* 1999; 282: 984-986.
4. Sullivan WM. Medicine under threat: professionalism and professional identity. *CMAJ* 2000; 162: 763-675. ❑

Hepatitis C: where are we at and where are we going?

We are making progress in our understanding of the hepatitis C virus, but there is still a long way to go

THE IDENTIFICATION of the hepatitis C virus (HCV) in 1989[1] delineated a disease previously masquerading under the title of "non-A, non-B hepatitis". In the ensuing years, hepatitis C has become a national epidemic, with more than 150 000 Australians known to be infected. It is estimated that an additional 11 000 new infections occurred each year during the 1990s.[2] Escalating rates of HCV infection will have enormous consequences, as 10%–15% of people infected have the potential to progress to end-stage liver disease, with all the implications that has for healthcare services in the years ahead.[3]

Australia has taken many unique steps in its handling of the hepatitis C epidemic. In 1994 and 1997, the National Health and Medical Research Council published two major reports from working parties comprised of specialists, general practitioners and community representatives.[4,5] These were seminal in directing approaches to the diagnosis, treatment and management of HCV-infected people and, to a lesser extent, prevention of further spread. Indeed, Australia was the first country to develop a National Strategy for HCV.[6,7] NSW Health has held successful Hepatitis C Awareness Weeks in 2000 and, more recently, in 2002, which have increased public awareness of many issues relating to HCV. NSW Health has recently released a Treatment and Care Plan for HCV, which, among other things, emphasises the importance of GPs in the evaluation and management of HCV-infected people.[8] The possibility of accrediting appropriately trained GPs to prescribe antiviral therapy for HCV is also discussed.

So, where are we going?

The recent report by the Anti-Discrimination Board of NSW on hepatitis-C-related discrimination presents compelling evidence that there is still much to be done if we as a society are to be seen to be dealing caringly and rationally with this disease.[9] The report highlights the disturbing reality that most discriminatory actions against people infected with HCV are perpetrated in healthcare settings.

The HCV Projections Working Group of the Australian National Council on AIDS, Hepatitis C and Related Diseases, which advises the federal Minister for Health on these diseases, will report later this year on the increasing rate of HCV acquisition, highlighting the imperative of improving our prevention strategies. The rate of infection is increasing, in large part, because an increasing number of young people are choosing to commence injecting drug use. While public messages on safe injecting practices are promoted widely, many young people ignore these messages in their early phase of drug use. The HCV antibody prevalence rate in those injecting for less than three years fell from 22% in