A new role for the royal colleges?

Ian Gilmore

The chief medical officer has given us 44 recommendations to ponder in his long awaited consultation document.¹ If we were scoring him on 44 questions, he might attain an enviable mark of 95%—yet still have two or three wrong answers in the report. It would be a mistake for the medical profession to dwell on the recommendations we don't like while missing the good within it. Certainly the Royal College of Physicians (RCP) welcomes much of the report. It has consulted widely, and most of its members are not stuck on the question of "if" in relation to the revalidation of their competence to practice and have moved on to those of "how" and "when."

But then, why did 750 doctors and patients sign a letter to the *Times* on 17 October, dismissing the report as an attempt to "deprofessionalise" doctors? Medical professionalism is a topic the RCP has looked at hard in the past year or so, in an attempt to update it in the context of changing values both in doctors and wider society.² In our report we noted: "Patients wish and are strongly disposed to trust doctors, though increasingly seek assurance that their trust is well placed—that there are systems of accountability in place to warrant it. Autonomy and accountability should not be seen solely as in tension, but as complementary, as counterpoised." Medical professionalism was seen as signifying a set of values, behaviours, and relationships that underpins the trust the public has in doctors, and appropriate accountability of doctors as the other side of the coin of what Onora O'Neill has called intelligent trust.³ Revalidation of our competence, if done appropriately, sits well with this position.

It is on this background that the RCP has considered the specific recommendations of specialist recertification, where the royal colleges and specialist associations are invited both to set standards of specialist practice and to assess against them. We agree that we are the bodies that have the skills for these tasks, and see the process as fitting well with the recently developed philosophy of medical professionalism described above. Of course the RCP does not underestimate the difficulties—for example, how to define the competencies of a doctor in geriatric or rehabilitation medicine. We know that measuring will not be a matter of counting mortality or coronary artery graft patency rates. How will the elements of individual competence be dissected out from the team performance? Are the data collected as part of routine clinical practice good enough to be used?⁴ What of the time needed for the doctor to collate meaningful data, and who will meet the costs of any new system?

The RCP has already set a framework, in partnership with the General Medical Council, in *Good Medical Practice for Physicians*, down to the level of each of its more than 20 specialisms. In addition, much has been achieved in the field of assessment for doctors in training that will be useful. Validated workplace tools for assessing clinical examination skills and

procedures now exist, and the RCP, like others, has developed workable multisource feedback or 360° review methods.⁵ It also has a long history of setting tests of knowledge through the MRCP examination and, currently, knowledge based assessments for higher trainees. But the college is not ready to say which will be most appropriate to use to demonstrate our "physicianly skills." Formal examinations would be neither widely popular with trained doctors nor an acceptable assessment tool in isolation for wider competence. However, awareness is growing that the wisdom of age does not necessarily compensate for slipping behind in new knowledge and information. The RCP has worked with the American Board of Internal Medicine recently and shared the experience of better tests of competence—over 70% of internal medicine specialists in the United States are now taking part in their voluntary accreditation schemes. The RCP's continuing professional development scheme has had a similarly high voluntary take-up by physicians.

It seems unwise to turn our back on all that has been achieved in assessment, saying that it applies only to the testing of new skills and competences for those in training and not to demonstrate keeping up to date. A range of methods can be adapted for specialist recertification, and individual clinicians may be able to choose the tool that suits their practice best. Individuals must be able to show competence in what they do now, not in what they may have done 20 years ago—and that will prove difficult in some areas of highly specialist practice. The colleges face risks: currently they are facilitators, helping their members to keep up to date, not regulators who may remove doctors' livelihood. In the model proposed by the chief medical officer the colleges will have to work through how the interface between them and the GMC, the keeper of the specialist register, will work. But if we don't get involved through our colleges and specialist associations, we run the serious risk of having some alternative board, less sensitive and clinically credible, imposed on us. We should learn from the lessons of postgraduate education, where the royal colleges' oversight has been lost to others. We need to stand up and take responsibility for demonstrating that patients' trust in their specialists is justified.

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- 3 O'Neill O. Accountability, trust and informed consent in medical practice and research. *Clin Med* 2004;4:267-76.
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- 5 Assessment guidelines (abridged). Joint Committee on Higher Medical Training. 2003. www.jchmt.org.uk/assessment/guidelines.asp (accessed 23 Oct 2006).

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Royal College of Physicians, London NW1 4LE
 Ian Gilmore
 president
 ian.gilmore@rcplondon.ac.uk

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