

Professional competence in medicine

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Professional competence in medicine is under the microscope following a year of government and media attention directed at the performance of doctors and outcomes for patients. The ability of the profession to self-regulate has been questioned and the roles of the state, the universities, the Royal colleges and the postgraduate deans are shifting. This paper provides a context for considering these important changes.

During recent years, there has been a radical change in the way that the medical profession is perceived by the public (Irvine, 1997a,b). But those of us in clinical practice also know that relationships between individual doctors and patients can still provide an opportunity for warmth, empathy, partnership, generosity and satisfaction for both participants. This difference between the public perception and private reality is well known to researchers who study patient satisfaction; satisfaction with doctors in general is normally lower than satisfaction with the respondents' own doctors.

What is certain is that patients expect doctors to be competent to diagnose, plan management and carry out practical procedures and they expect them to behave in a reasonable way while they do so. In particular they expect a doctor to listen as well as talk, pay attention, take time to explain and to show some understanding of the anxieties that the patient brings to the conversation (Stewart, 1995; Stewart et al, 1995). Failure to give competent care and/or failure to communicate adequately leads to complaints; at its worst the masking of incompetent clinical practice by apparent empathy and good communication if discovered, leads to revulsion on the part of the patient. This was a prominent feature of the emotions expressed by the families of the children in the Bristol case who felt that their trust had been betrayed.

THE INTERNATIONAL SCENE

The changes in the relationship between the medical profession and the public reflect international trends. In both North America and the UK the pressure for greater accountability is being felt at all levels of practitioner

governance and regulation (Southgate and Dauphinee, 1998). The trend is characterized by a movement away from setting standards for entry into practice to maintaining standards in practice (Parboosingh, 1998) and to achieving targets in relation to patient and service outcome measures (Bashook and Parboosingh, 1998).

Two powerful influences are the need to control health-care costs while maintaining quality and the increasing role of lay members on the governing boards of regulatory bodies which has opened the self-governance of the profession to wider scrutiny (Topol and Califf, 1994; Green and Winfield, 1995; General Medical Council (GMC), 1998a). Health reforms in the UK which emphasize cost effectiveness, clinical effectiveness and evidence-based medicine have also contributed to a focus on the performance of doctors in clinical practice (Secretary of State for Health, 1996b). The theme of the professional competence of doctors has moved to centre stage both in government policy documents and all sections of the British media.

WHAT IS PROFESSIONAL COMPETENCE IN MEDICINE?

The international literature contains many definitions of the professional skills and knowledge required for the demonstration of competence in medicine. From the 1970s onwards particular attention has been directed at the moral and personality attributes which are important components of competence, but which had received less attention. Groups which have attempted to name the humanistic qualities that characterize competence have invariably reported difficulty in their precise definition: nevertheless there has long been

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widespread agreement that it is important to try. Although they are infrequently assessed, these qualities are highly valued by society. This has been reflected more recently in the reforms within undergraduate education including the pre-registration house officer year, the changes in higher specialist training and the introduction of the GMC performance procedures. All of these programmes are based on a wider definition of professional competence in medicine, ultimately defined by the GMC in its publication *Duties of a Doctor. Good Medical Practice* (GMC, 1998b).

The definition of clinical competence is highly context bound, and the role of doctors in the societies in which they will ultimately practice should determine the professional behaviour that they will be expected to demonstrate. This assertion has profound implications for the relationship of the profession to society and the state, and for the participation of the community and the state in defining and assessing clinical competence. In the UK there is a developing trend to involve lay people in peer review of clinical practice, and in one postgraduate examination (the MRCGP) a lay person is present at the meeting where standards for pass/fail are set in order to bring the public perspective.

A DEFINITION OF COMPETENCE

Competence is composed of cognitive and interpersonal skills, moral and personality attributes.

'It is in part the ability, in part the will, to consistently select and perform relevant clinical tasks in the context of the social environment in order to resolve health problems of individuals and groups in an efficient, effective, economic and humane manner'
(Southgate, 1994).

In addition the absence of any one of honesty, self-awareness, empathy, respect for confidentiality and patient autonomy will compromise competence.

While every clinician will demonstrate competence in a unique clinical practice, learning from every patient and situation, there is a common core of practice that distinguishes an individual as a member of the medical profession. It contains knowledge, attitudes and skills which any doctor who engages in independent practice in any branch of the profession, including the non-clinical branches, should exhibit. These include moral and ethical behaviour in the practice setting, humanistic skills and the skills necessary to maintain compe-

tence within their chosen field. A critical approach to their own work, a willingness to engage in medical audit and a commitment to independent learning are therefore all characteristics to be expected of any competent physician (Southgate and Jolly, 1994).

THE RELATIONSHIP BETWEEN COMPETENCE AND PERFORMANCE

This definition of competence emphasizes both the ability and the will to act: knowing and showing how to act does not necessarily guarantee that a doctor will act in that way in everyday practice. This difference between competence and performance is important; tiredness, poor facilities, burnout, domestic problems and ill health can all compromise performance, but so can arrogance or contempt for patients or colleagues.

The relationship between competence and performance is more than just an academic consideration because assessment of competence is the usual way to mark career progression in medicine. But it does not always predict performance in later practice, particularly if the methods of assessment of competence are invalid or unreliable as has unfortunately too often been the case (Newble, 1994).

In the current climate in the UK, attention is increasingly focussed on using outcome measures as performance indicators for organizations, teams and individuals. The introduction of national service frameworks, health improvement plans and clinical governance reflect this shift away from professionally determined standards assessed by tests of competence or in-training assessments supported in many instances by inadequate documentation unlikely to stand legal challenge, to outcome measures which may not be evidence based, supported by accurate data or able to clarify the contribution of different individuals or groups to the results.

Underneath these changes lies the realignment of the respective roles of the state, the Royal colleges, the universities, the postgraduate deans and the GMC in regulating the profession and setting standards for clinical practice (British Medical Association et al, 1998). All changed, changed utterly was not an over-reaction to the recent events at the GMC (Smith, 1998).

ASSESSMENT OF COMPETENCE WITHIN THE GMC PERFORMANCE PROCEDURES

Most doctors in busy clinical practice, including most readers of this article, are interested in gaining more experience, seeing patients, and

developing and refining their practical skills. They relish the intellectual challenge of medicine and the satisfaction of doing a job well. But the issues addressed above will not go away and they will permeate all aspects of professional practice. The wider definition of clinical competence now dictates that assessments at all stages of education, training and established practice will include communication skills, teamworking, the ethical and legal framework of practice and the ability to respond to feedback, as well as knowledge of clinical medicine and the science that underpins it.

For the last 6 years, the author has led the work to develop the assessments of performance for doctors who are referred into the GMC performance procedures. They are based on the standards in *Good Medical Practice* as expressed within the clinical practice of the doctor under review. The procedures are now law and the first doctor has been suspended following an assessment which provided evidence that withstood legal challenge.

The assessment is in two phases. The first consists of a 2-day peer-review visit to the place of practice with assessments of medical record-keeping, discussions of actual cases, observation of outpatient consultations, interviews with the doctor and interviews with at least 12 colleagues, medical and non-medical, who work with the doctor. The second phase includes tests of knowledge, clinical method, consulting skills and practical skills. Lay assessors have played an equal role with doctors in the development of the assessment programme and each assessment team includes a lay assessor who brings the public perspective to all aspects of both phases. The assessments are extremely detailed and practical, resulting in a very full description of the professional performance of the doctor under review.

Cases so far have involved doctors from all grades including a GP trainee and an established consultant, from the disciplines of anaesthetics, paediatrics, obstetrics and gynaecology and accident and emergency. Our approach to the assessment of performance and competence has had an effect on the development of several Royal college examinations, which have started to consider other ways of assessing communication and practical skills.

The performance procedures are designed to protect minimum standards and are relevant to a very small proportion of the profession. But the wider definition of professional competence on which they are based, and the rigour with which they have been developed send a powerful mes-

sage to the profession and the public. The paradox in the message for tired and demoralized competent doctors is that it gives you support to be the doctor you probably set out to be when you went to medical school; competent and humane and finding satisfaction in your work. **HM**

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KEY POINTS

- Modern definitions of professional competence encompass values and attitudes in addition to clinical knowledge and skills.
- Changes in society have had a profound impact on the relationship between doctors and patients with a greater pressure for accountability.
- Emphasis is now on maintenance of competence to practice and outcomes for patients rather than on setting standards for entry to the profession.
- These changes have led to new methods of assessment of competence with the focus on peer review of performance in practice rather than passing examinations.
- The involvement of lay people in assessing performance and setting standards will become increasingly important in building public confidence.